



Adamsville Healing Arts Center

for therapeutic massage

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (h): _____ (c): _____ (w): _____

Birth Date: _____ / _____ / _____ Email Address: _____

Male Female Referred by: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Do you wear contacts? _____ Do you Exercise? _____ If yes, how: _____

How much water do you drink in a day? _____ Do you consider yourself stressed? _____

Is this your first Professional Massage? _____ If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage? _____

Are you aware of any tension holding spots in your body? _____ If yes, location(s) _____

Describe any surgeries, hospitalizations, accidents or injuries you have had: _____

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel you have recovered from these events? _____ Please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____ Please explain: _____

Describe what activities cause this pain and/or make it worse: _____

Are you currently receiving any other type of medical or therapeutic treatment? _____ Please explain: _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals. Include an explanation of what the medication is used to treat: _____

Are you currently under the care of a physician? _____ Whom? _____

Please list reason(s): _____

Are there any health concerns you wish to discuss today? _____ If yes, Please describe: _____

(over please...)

Are you currently experiencing any of the following conditions?

- Flu or Cold
- Inflammation
- Fever
- Infection
- Contagious Disease

Please check (√) any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

CIRCULATORY SYSTEM

- Anemia
- Hemophilia
- Hypertension
- Low Blood Pressure
- Raynaud's Disease
- Varicose Veins
- Heart Condition
- Blood Clots/Phlebitis
- Diabetes
- Swelling
- Other _____

DIGESTIVE SYSTEM

- Ulcers
- Irritable Bowel Syndrome
- Colitis
- Gallstones
- Hepatitis
- Crohn's Disease
- Diarrhea
- Gas/Bloating
- Indigestion
- Bleeding
- Constipation
- Difficulty Swallowing
- Other _____

SKIN

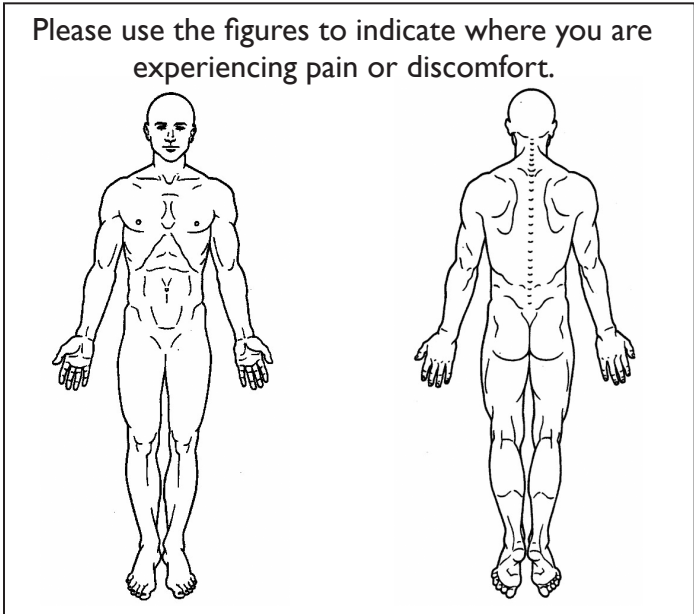
- Fungal Infections
- Acne
- Impetigo
- Dermatitis/Eczema
- Psoriasis
- Open Wound or Sore
- Rashes
- Warts/Moles
- Athletes Foot
- Other _____

RESPIRATORY SYSTEM

- Pneumonia
- Sinusitis
- Asthma
- Trouble Breathing
- Dizziness
- Other _____

MUSCULOSKELETAL SYSTEM

- Fibromyalgia
- Spasms/Cramps
- Sprains/Strains
- Osteoporosis
- Postural Deviations
- Gout
- Osteoarthritis/Rheumatoid Arthritis
- TMJ
- Cysts
- Bursitis
- Plantar Fasciitis
- Tendonitis
- Torticollis
- Whiplash Syndrome
- Carpal Tunnel Syndrome
- Sciatica
- Thoracic Outlet Syndrome
- Leg Pain
- Ann Pain/Shoulder Pain
- Low Back Pain
- Mid Back Pain
- Hip Pain
- Other _____



NERVOUS SYSTEM

- ALS
- Multiple Sclerosis
- Parkinson's Disease
- Bell's Palsy
- Neuritis
- Spinal Cord Injury
- Stroke
- Trigeminal Neuralgia
- Seizure Disorders
- Numbness/Tingling/Twitching
- Other _____

OTHER

- Insomnia
- Sleep Apnea
- Anxiety/Panic Attacks
- Physical/Emotional Abuse
- Substance Abuse
- Grief Process
- Cancer
- Chronic fatigue Syndrome
- HIV/AIDS
- Lupus
- Kidney Disease
- Bladder Infection
- Postoperative Situation
- Depression
- Migraines
- Frequent Headaches
- Ear/nose/throat infection
- Glaucoma
- Visions problems
- Other _____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention and examination. I take full responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature _____ Date: _____