

Massage Client Health Information

Carol Connett, LMT

Please print clearly.

NAME _____ Date _____

Sex M F
PLEASE CIRCLE Age _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Business/Work Phone _____ Cell Phone _____ Occupation _____

Company Name & Address (Work) _____

In Emergency Notify _____ Phone _____

Family Physician _____

Who Referred You to this Office? _____

If you have a chronic condition is it due to an accident? Please check: Yes No Is it work related? Yes No

Other _____

Please circle any of the following that you have presently, or have had in the past:

LYMPH, BLOOD OR IMMUNE SYSTEM DISORDERS

Impetigo Lymphangitis Diabetes Cancer HIV-AIDS Other _____

CIRCULATORY DISORDERS

Arteriosclerosis Heart Disease Varicose Veins Phlebitis/Thrombosis High Blood Pressure Swelling

Other _____

INFLAMMATORY CONDITIONS

Herniated Disks Rheumatoid Arthritis Acute Fevers Fibrositis Gout Other _____

OTHER DISORDERS

Epilepsy Osteoporosis/Osteoarthritis Nail Fungus Athletes Foot Warts Rashes

Other _____

Have you had a recent accident, injury or illness (...or longer if it still affects you)? If yes, please describe.

Please check: Yes No _____

Have you ever had a professional massage before? Please check: Yes No

Have you ever had a negative effect from or unpleasant experience during a massage? Please check: Yes No

If the answer above was yes, please explain briefly what made it unpleasant: _____

Do you have any allergies to oils, nuts, lotions or scents? _____

Have you ever reacted to shellfish, iodine, or any other health or beauty products? _____

Would you prefer a scented or unscented oil for your massage? Scented _____ Unscented _____

Are you sensitive to heat? (Example: skin sensitivity, hot flashes, etc.) _____

Are you currently taking any medications (Example: pain-killers, muscle relaxers, etc.)? _____

Please mark or circle painful or distressed areas in the figures below.

