CLIENT INFORMATION

Holly A. Wall, BCTMB, LMT
Massage Therapist & Emotion/Body Code Practitioner

Nature's Path
Massage & Healing Arts

Client Information

Name _____ Phone _____

Address _____ _____

Birthdate _____ Email _____

Emergency Contact _____ Phone _____

Referred by _____ _____

Massage History/Session Information

Have you ever received a professional bodywork session before? Yes_____ No_____

What is your intention or expectation for this visit today?_____

_____

Top 3 Major Complaints/Conditions that you are seeking assistance with *today.*

1) _____
2) _____
3) _____

When did you first notice the above condition(s)? _____

What aggravates or what helps give relief? _____

Have you obtained a medical diagnosis? _____

List any exercise activities. Include frequency:_____

_____

Please list any current prescription medications, nutritional supplements, or over the counter remedies you are taking and why. _____

_____

List other therapies or treatments you receive on a regular basis. _____

_____

Previous History

(Please indicate the date, source, and type of any past injuries, illness, traumas, or surgeries)

On/Since	Nature of disorder	Source (if known)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you pregnant? Yes/No *If yes, please answer the following questions*:

Due date: _____ Have you ever had a pregnancy massage before? Yes/No If yes, when? _____

Care Provider's Name/City: _____ Any Concerns/Issues with this pregnancy? _____

If yes, what? _____

Please check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- □ Headaches
- □ Joint Stiffness/swelling
- □ Spasms/cramps
- □ Broken/fractured bones
- □ Strains/Sprains
- □ Back/Hip Pain
- □ Shoulder/neck/arm/hand pain
- □ Leg/ Foot pain
- □ Chest/Ribs/ Abdominal pain
- □ Problems Walking
- □ Jaw Pain/TMJ
- □ Tendinitis/ Bursitis
- □ Arthritis
- □ Scoliosis
- □ Bone or Join disease
- □ Other:_____

Circulatory and Respiratory

- □ Dizziness/Fainting
- □ Shortness of Breath
- □ Cold Hands/ Feet
- □ Cold Sweats
- □ Swollen Ankles
- □ Varicose Veins
- □ Blood Clots
- □ Stroke/Heart Condition
- □ Allergies/Sinus problems
- □ Asthma
- □ High or Low blood pressure
- □ Lymphedema
- □ Other: _____

Skin

- □ Rashes
- □ Allergies
- □ Acne
- □ Warts or Moles
- □ Cosmetic Surgery
- □ Other: _____

Digestive

- □ Indigestion
- □ Constipatoion
- □ Intestinal gas/bloating
- □ Diarrhea
- □ Diverticulitis
- □ Irrititable Bowel syndrome
- □ Crohn's Disease
- □ Other:_____

Nervous System

- □ Numbness/tingling
- □ Twitching of face
- □ Fatique
- □ Chronic Pain
- □ Sleep Disorders
- □ Ulcers
- □ Paralysis
- □ Herpes/Shingles
- □ Chronic Fatique Syndrome
- □ Parkinson's disease
- □ Other disease not listed:

_____

Reproductive System

- □ Pregnant? Y/N
  Due date:_____
- □ PMS
- □ Menopause
- □ Pelvic Inflammatory Disease
- □ Endometriosis
- □ Hysterectomy? Y/N Yr: _____
- □ Fertility Concerns:_____
- □ Prostate Problems
- □ Other: _____

Other

- □ Loss of Appetite
- □ Forgetfulness
- □ Confusion
- □ Depression
- □ Difficulty concentrating
- □ Drug Use_____
- □ Alcohol Use_____
- □ Nicotine Use _____
- □ Hearing/Balance Impairment
- □ Visually Impaired
- □ Eating Disorder
- □ Diabetes
- □ Fibromyalgia
- □ Post Polio Syndrome
- □ Chronic Fatique Syndrome
- □ Cancer
- □ Other: _____

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required. Because massage/bodywork may be contraindicated for certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner update as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. I understand massage therapists and bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment. I understand cancellations made with less than 48 hours notice, late arrivals, and no-shows will be liable for the cost of the full session.

Signed _____ Date: _____