

# Well Balanced Massage

## Client Information

Date \_\_\_\_\_

Name \_\_\_\_\_ Email \_\_\_\_\_

Phone (Cell) \_\_\_\_\_ Phone (Home) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

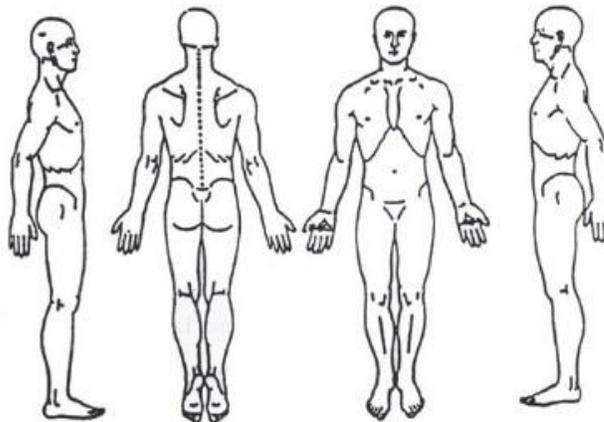
Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes  No   
If yes, when was your last one? \_\_\_\_\_ How often do you receive massage therapy? \_\_\_\_\_
2. Do you have any difficulty lying on your front, back, or side? Yes  No   
If yes, please explain \_\_\_\_\_
3. Do you have any allergies to oils, essential oils, lotions, or ointments? Yes  No   
If yes, please explain \_\_\_\_\_
4. Do you have sensitive skin? Yes  No
5. Are you wearing any of the following? Contact lenses  Dentures  Hearing aid
6. Do you sit for long hours at a workstation, computer, or driving? Yes  No   
If yes, please describe \_\_\_\_\_
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes  No   
If yes, please describe \_\_\_\_\_
8. Do you experience stress in your work, family, or other aspect of your life? Yes  No   
If yes, how do you think it has affected your health?  
Muscle tension  Anxiety  Insomnia  Irritability  Other \_\_\_\_\_
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?  
Yes  No  If yes, please identify \_\_\_\_\_
10. What goals do you have in mind for this massage session? Relaxation  Stretching  Tension Release   
Other \_\_\_\_\_

Circle any specific areas you would like the massage therapist to concentrate on during the session.



# Well Balanced Massage

## Medical History

In order to plan a massage session that is safe and effective, some general information about your medical history is helpful.

11. Are you currently under medical supervision? Yes  No

If yes, please explain \_\_\_\_\_

12. Do you see a chiropractor? Yes  No  If yes, how often? \_\_\_\_\_

13. Are you currently taking any medication? Yes  No

If yes, please list \_\_\_\_\_

14. Please check any condition listed below that applies to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Contagious skin condition  | <input type="checkbox"/> Phlebitis   |
| <input type="checkbox"/> Open sores or wounds       | <input type="checkbox"/> Deep vein thrombosis/blood clots                              |
| <input type="checkbox"/> Easy bruising              | <input type="checkbox"/> Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> Recent accident or injury  | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Recent surgery             | <input type="checkbox"/> Epilepsy  |
| <input type="checkbox"/> Artificial joint           | <input type="checkbox"/> Headaches/Migraines   |
| <input type="checkbox"/> Sprains/Strains            | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> Current fever              | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Swollen glands             | <input type="checkbox"/> Decreased sensation   |
| <input type="checkbox"/> Allergies/Sensitivity      | <input type="checkbox"/> Back/Neck problems  |
| <input type="checkbox"/> Heart condition            | <input type="checkbox"/> Fibromyalgia  |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> TMJ   |
| <input type="checkbox"/> Circulatory disorder       | <input type="checkbox"/> Carpal Tunnel syndrome  |
| <input type="checkbox"/> Varicose veins             | <input type="checkbox"/> Tennis elbow  |
| <input type="checkbox"/> Atherosclerosis            | <input type="checkbox"/> Pregnancy If yes, how many months? _____                      |

Please explain any condition that you have marked above \_\_\_\_\_

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? \_\_\_\_\_

## Consent

I, \_\_\_\_\_ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists 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 given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapy reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Massage Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_