Confidential Client History

Hands for you, LLC
Mind & Body Healthcare
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www.amtamembers.com/hands4you

Please complete this questionnaire. Your answer will help us to achieve maximum benefits from your massage session(s). **THANK YOU!**

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Z Code: _____

Home Phone _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer: _____

Birth Date: _____ Age: _____ Referred by: _____

How do you prefer to be addressed? (Circle one) Mr. / Mrs. / Ms. / Dr. / First Name

Reasons for wanting massage: _____

Date of last professional massage: _____ Frequency: _____

Please prioritize areas of your body you prefer to have massage:

_____

Do you wear contacts? _____ If YES, are they in now? _____

Are you pregnant? _____ If YES, what is your due date? _____

Are you currently seeing a health care provider? _____ If YES, please explain:

_____

Are you taking prescription OR over-the –counter medication? _____

_____

Is your life stressful? _____ Please describe: _____

_____

Are you currently experiencing emotional difficulties? _____

Please list illness, injuries and surgeries:

Illnesses: _____

Injuries: _____

Surgeries: _____

Is there anything else we should know about you? _____

Do you have a history of any of the following? Please check if "yes"

Musculoskeletal:

___ Bone or joint disease
___ Arthritis
___ Sprains / Strains
___ Low back pain
___ Mid / Upper back Pain
___ Hip / leg pain
___ Neck pain
___ Shoulder / arm pain
___ Headaches
___ Jaw pain / clicking / popping
___ Clenching or grinding teeth
___ Spasms / Cramps
___ Spinal curvature
___ Fibromyalgia
___ Other

Skin:

___ Rashes
___ Bruise easily
___ Sensitive Skin
___ Hives / allergies
___ Other

Nicotine / Caffeine use:

_____

Digestive:

___ Constipation
___ Gas / Bloating
___ Hiatal hernia
___ Other

Respiratory / Circulatory:

___ High blood pressure
___ Breathing difficulties
___ Varicose Veins
___ Other cardiovascular problems
___ Other

For Women Only:

___ Painful menstruation
___ Yeast infections
___ Breast lumps / masses
___ Otrher _____

Fatigue

___ Difficulty sleeping
___ Diabetes
___ Drug / alcohol addiction
___ Other _____

Neurological:

___ Herpes / shingles
___ Numbness / tingling
___ Chronic pain
___ Dizziness (any cause)
___ Other _____

Genitourinary:

___ Kidney infections
___ Kidney stones
___ Prostate problems
___ Other _____

Other:

___ Allergies (any)
___ Sinus problems
___ Cancer / tumor

Infectious disease:

___ Disease names(s):

_____

_____

I have provided you (Massage Therapist) with the initial information you need to know to plan and treat me. My medical history, as well as current conditions will allow you to determine if any pre-existing condition may contraindicate massage.

PLEASE SIGN BELOW

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical or chiropractic treatment, or pharmaceuticals. It is in no way intended to be substitute for professional health care.

I have stated all medical conditions of which I am aware, and will update the massage therapist of any changes in my health status.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____