

Ultimate Massage

“Our Ultimate Goal is Your Well-being”

Your answers to these questions are kept confidential and seen only by your therapist.

Knowing you, and your body, will help us provide you with the best care possible!

Client Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ E-Mail: _____

What type of work do you do? _____

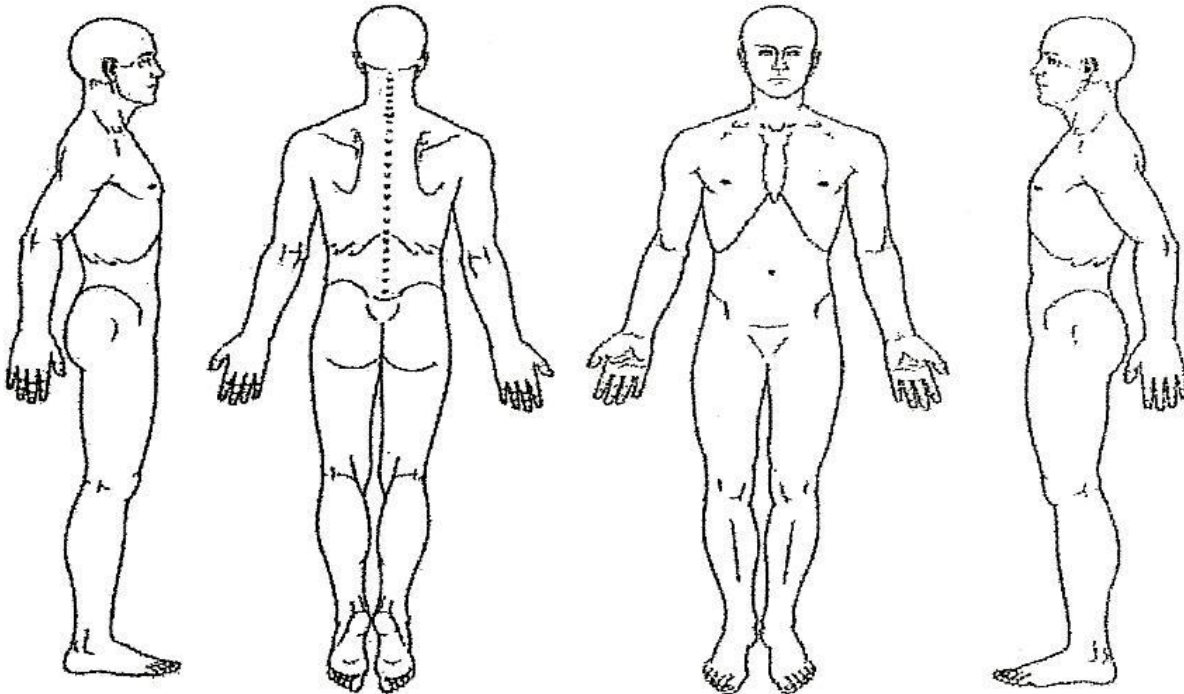
How would you characterize your frequency of massage? Never Rare Occasional Habitual

What would you like from your session today? (please circle all that apply)

Relaxation/Stress Reduction Pain Relief Injury Recovery (date of injury: _____)
Increased Body Awareness To Feel Good! Other _____

Are any areas of your body feeling stiff/sore/achy or uncomfortable? _____

Please place a **✓** on the areas you would like me to focus, and an **✗** on any areas I should avoid.



Complete and Sign back  Turn Over

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Are you currently seeing a health care professional? _____ Yes _____ No

If yes, please list name(s) and reason/treatment: _____

Are you currently taking any medications? _____ Yes _____ No

If yes, please list name and reason for medication: _____

Are you currently pregnant? _____ Yes _____ No

If yes, when is your due date? _____

Do you have any of the following today?

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Severe Pain |
| <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Anything Contagious |
| <input type="checkbox"/> Open Cuts | <input type="checkbox"/> Injuries/Bruises |

Do you have any allergies to:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Environmental Allergens |
| <input type="checkbox"/> Foods | <input type="checkbox"/> Reactions to Skin Care Products |

If any of the above are checked, please give details: _____

Please review the following list and check those conditions that have affected your health either recently or in the past.

- | | |
|---|---|
| <input type="checkbox"/> Arthritis (where: _____) | <input type="checkbox"/> Headaches/Migraines. How often? _____ |
| <input type="checkbox"/> Anxiety and/or Panic Disorder | <input type="checkbox"/> Heart Conditions: _____ |
| <input type="checkbox"/> Auto-Immune Conditions: _____ | <input type="checkbox"/> Hepatitis (A, B, C, other) |
| <input type="checkbox"/> Back Pain/Problems. Herniated discs? _____ | <input type="checkbox"/> High Blood Pressure. Regulated? ___ Yes ___ No |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscle Sprain/Strain (where/when: _____) |
| <input type="checkbox"/> Diverticulitis, Irritable Bowel, Crohn's Disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Broken Bones (where/when: _____) | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Stroke (when: _____) |
| <input type="checkbox"/> Cancer. Type: _____ In Remission? _____ | <input type="checkbox"/> Surgery (where/when: _____) |
| <input type="checkbox"/> Chronic Pain (where: _____) | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Whiplash (when: _____) |

The therapist and client must openly communicate about any issues that may affect the client's treatment and responsiveness to treatment; it is important the client let the therapist know of any known issues, and also of any changes that may affect treatment. The services provided are not a replacement for medical or psychological care. Any information we provide is not prescriptive or diagnostic in nature, and is intended only to educate. In order to provide the client with the best and most appropriate treatment, we may discuss information pertinent to the client's condition(s) with associated LMTs, and/or with the health care providers the client has listed above.

Please indicate that you understand and consent to the above by signing and dating below.

Client Signature: _____

Date: _____

THERAPIST: _____

NOTES: _____

