Client Record: Massage

Please complete this form. This information is critical to your session(s) as it may affect the focus and outcome of it. All information disclosed will be kept for session purposes only and in strict confidentiality.

Name_____Date_____Therapist_____

Massage History/Information

Have you ever received Massage Therapy? Yes___ No___ Date of last massage: _____

Are there any areas you DISLIKE to be massaged? (Ex: face, scalp, feet, abdomen, buttocks) _____

_____

Have you (ever) been diagnosed with Deep Vein Thrombosis or a history of blood clots? If so, please explain:

_____

Please mark the correct box for any conditions that you currently have or have had in the past:

- ☐ Allergies
- ☐ Bone/Joint Disease
- ☐ Bone/Joint Injury
- ☐ Hepatitis A, B, or C
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Headaches/Migraines
- ☐ Head Injuries
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Botox or filler injections
- ☐ HIV/AIDS
- ☐ Jaw Pain/TMJ
- ☐ Lower Back/Hip Pain
- ☐ Muscle Spasms
- ☐ Numbness/Swelling
- ☐ Pacemaker
- ☐ Painful Feet/Swelling
- ☐ Pregnant? # wks___
- ☐ Stiffness
- ☐ Tendonitis
- ☐ Vertigo
- ☐ Warts

Please indicate the primary reason(s) for your visit today:

- ☐ Relaxation
- ☐ Pampering
- ☐ Stress Relief
- ☐ Therapeutic
- ☐ Pain Management
- ☐ Other: _____

****If you experience any pain during the session(s), please immediately inform the therapist, so that the work can be adjusted to your level of comfort.**

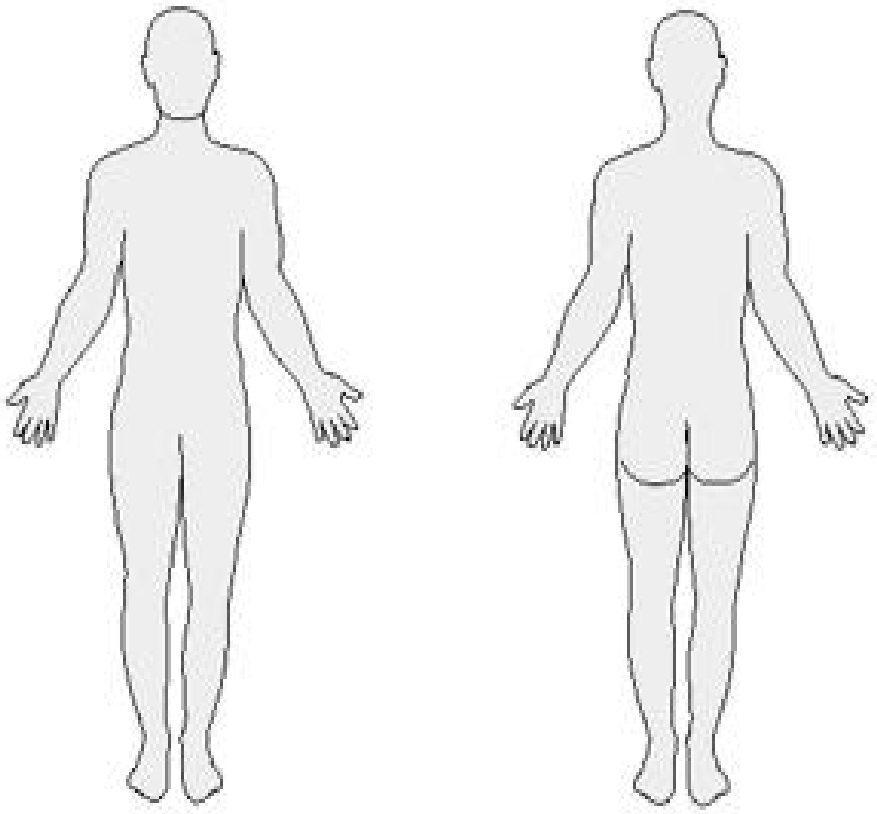
I understand that the services I receive are provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. I further understand that massage/bodywork should not be a substitute for medical examination, diagnosis, or treatment.

Please indicate if signing for a child. Yes____ No____

Signature_____ Date_____

PLEASE COMPLETE DIAGRAM ON REVERSE SIDE >

Please indicate all areas that you would like your therapist to focus on.



FOR THERAPIST USE:

OBJECTIVE

Muscle/Region	Right	Left
Paraspinals	☐	☐
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐
Sacral	☐	☐
SCM	☐	☐
Scalenes	☐	☐
Pectoralis	☐	☐
Suboccipital	☐	☐
Deltoids	☐	☐
Trapezius	☐	☐
Upper	☐	☐
Middle	☐	☐
Lower	☐	☐
Levator Scapula	☐	☐
Rhomboids	☐	☐
Rotator Cuff	☐	☐
Biceps	☐	☐
Triceps	☐	☐
Quad. Lumbar	☐	☐
Abdominals	☐	☐
Iliopsoas	☐	☐
Quadriceps	☐	☐
Hamstrings	☐	☐
Gluteus	☐	☐
Maximus	☐	☐
Medius	☐	☐
Minimus	☐	☐
TFL/IT Band	☐	☐
Adductors	☐	☐

Therapist Notes: