Healthcare Partners
Family Medicine

# MASSAGE & BODYWORK
# CLIENT INFORMATION

**Name** _____ **Home phone** _____ **Wk phone** _____
**Address** _____

**City, State, Zip** _____ **D.O.B.** _____

**In case of emergency notify** _____ **Phone** _____

**Referred by** _____ **Phone** _____

**Type of work, sports and activities you engage in:** _____

## GENERAL & MEDICAL INFORMATION

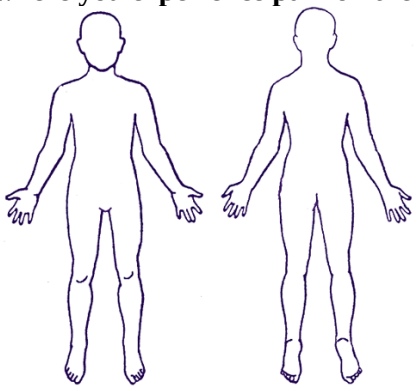
**Please circle YES or NO. If you answer "YES" to any questions below, please explain as clearly as possible.**

| | | | | | |
|---|---|---|---|---|---|
| **Do you frequently suffer from stress?** | **Y** | **N** | **Do you experience frequent headaches?** | **Y** | **N** |
| **Are you pregnant?** | **Y** | **N** | **Are you wearing contact lenses?** | **Y** | **N** |
| **Are you diabetic?** | **Y** | **N** | **Are you epileptic?** | **Y** | **N** |
| **Have you broken any bones in the last 2 yrs** | **Y** | **N** | **Do you have tension in a specific area?** | **Y** | **N** |
| **Do you have numbness anywhere?** | **Y** | **N** | **Do you have circulatory problems?** | **Y** | **N** |
| **Are you sensitive to pressure in any area?** | **Y** | **N** | **Do you have stabbing pain anywhere** | **Y** | **N** |
| **Do you have high blood pressure?** | **Y** | **N** | **Do you suffer from constant back pain?** | **Y** | **N** |
| **Do you have cardiac problems?** | **Y** | **N** | **Have you ever had surgery?** | **Y** | **N** |

**List any surgeries and approximate dates:** _____
_____
**List current medication(s)** _____
**If applicable, list any other medical problems I should be aware of. N/A** _____
_____
_____

**Are you currently experiencing any of the following conditions? (Yes or No)**
**____Flu or cold ____ Inflammation ____Fever ___Infection _____Contagious Disease**

**Please indicate where you experience pain on the drawing below:**



**Please check any of the following conditions below that currently affect you or that you have experienced in the last five (5) years:**

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# MASSAGE & BODYWORK CLIENT INFORMATION

## MUSCULOSKELETAL

___ Fibromyalgia
___ Spasms/Cramps
___ Sprains/Strains
___ Osteoporosis
___ Postural Deviations
___ Gout
___ Osteoarthritis/Rheumatoid Arthritis
___TMJ Dysfunction
___ Cysts
___ Bursitis
___ Plantar Fascitis
___ Tendonitis
___ Torticollis
___ Whiplash Syndrome
___ Carpal Tunnel Syndrome
___ Sciatica
___ Thoracic Outlet Synd.
___ Headache
___ Leg Pain
___ Arm Pain/Shoulder Pain
___ Low Back Pain
___ Mid Back Pain
___ Hip Pain
___ Other

## RESPIRATORY

___ Pneumonia
___ Sinusitis
___ Asthma
___ Trouble Breathing
___ Dizziness
___ Other

## CIRCULATORY

___Anemia
___ Hemophilia
___ Hypertension
___ Low Blood Pressure
___ Raynaud's Disease
___ Varicose Veins
___ Heart Condition
___ Blood Clots/Phlebitis
___ Diabetes
___ Other

## DIGESTIVE

___ Ulcers
___ Irritable bowel syndrome
___ Colitis
___ Gallstones
___ Hepatitis
___ Crohn's Disease
___ Diarrhea
___ Gas/Bloating
___ Indigestion
___ Other

## SKIN

___ Fungal Infections – Acne
___ Athletes Foot
___ Impetigo
___ Dermatitis/Eczema
___ Psoriasis
___ Open Wound or Sore
___ Rashes
___ Warts/Moles
___ Other

## NERVOUS SYSTEM

___ ALS
___ Multiple sclerosis
___ Parkinson's Disease
___ Bell's Palsy
___ Neuritis
___ Spinal Cord Injury
___ Stroke
___ Trigeminal Neuralgia
___ Seizure Disorders
___ Numbness/Tingling/Twitching
___ Other

## OTHER

___ Insomnia
___ Sleep Apnea
___ Anxiety/Panic Attacks
___ PMS
___ Physical/Emotional Abuse
___ Grief Process
___ Cancer
___ Substance Abuse
___ Pregnancy
___ Chronic Fatigue
___ HIV/AIDS
___ Lupus
___ Kidney Disease
___ Bladder Infection
___ Postoperative Situation
___ Edema
___ Other

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I affirm that I have stated all my known medical conditions and answered all questions honestly. I attest that I have read, understood, and agree with the Therapist and Client Rights and Responsibilities information sheet that has been given to me.

**Patient Name** **Patient Signature** **Date**

Updated: 3/11/2015