

Mark Duval, CMT
Confidential Health Information
Please Print

Client Name _____ Phone(s) _____

Address _____ Zip Code _____

Date of Birth _____ Emergency Contact & Phone _____

Email address _____

What is your primary reason for wanting massage at this time? _____

If you have a major complaint, when did you first notice it? _____

Is this condition interfering with your _____ work? _____ sleep? _____ daily routine? _____

Please list any medications you are taking and what they are for:

Have you had massage therapy before? yes no Are you sensitive to touch or pressure in any area? _____

How much water do you drink daily? _____

Health History

Musculo-Skeletal

__ joint pain / arthritis _____

__ sprains / strains _____

__ low back / hip / leg pain _____

__ neck / shoulder / arm pain _____

__ headaches / head injury _____

__ spasms, cramps _____

__ jaw pain / TMD _____

__ sciatic pain _____

__ carpal tunnel _____

__ broken bones _____

__ inflammation / bursitis, tendonitis _____

__ foot pain _____

Circulatory / Respiratory

__ heart condition _____

__ varicose veins _____

__ high / low blood pressure _____

__ blood clots _____

__ breathing difficulty _____

__ sinus problems _____

__ airborne allergy / sensitivity _____

__ cold hands / feet _____

Infectious or other diseases _____

Skin

__ allergies _____

__ rashes _____

Surgeries / Injuries _____

Digestive / Eliminate

__ constipation _____

__ gas / bloating _____

__ other _____

Nervous system

__ numbness / tingling _____

__ sleep disorders _____

__ herpes / shingles _____

__ other _____

Reproductive

__ pregnant? trimester _____

__ painful menstruation _____

__ prostate _____

__ other _____

Other

__ cancer / tumors _____

__ diabetes _____

__ autoimmune disorder _____

__ depression _____

__ anxiety / nervousness _____

__ compulsive behavior _____

__ other _____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. I agree to communicate with my practitioner any time I am not pleased or comfortable with the work I am receiving.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I also agree to pay for all services at the time they are rendered unless prior arrangements have been made.

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

signature

date