Date:_______________

THERAPEUTIC MASSAGE CLIENT HISTORY FORM

PLEASE FILL THIS FORM OUT TO THE BEST OF YOUR ABILITY. THE INFORMATION IS VERY IMPORTANT TO BE **ACCURATE AND UPDATED** IN ORDER TO PERFORM A SAFE AND EFFECTIVE TREATMENT. IT IS COMPLETELY CONFIDENTIAL AND WILL NOT BE SHARED WITHOUT YOUR WRITTEN CONSENT.

Client Name: ______________________________ Phone: ___________________ DOB:_______________

Address: __________________________________ City: ____________________ Postal Code: __________

Email: ____

Emergency Contact: _____________________________________ Phone: ___________________________

Primary HealthCare Provider: _______________________________MCP #: __________________________

Insurance Coverage Provider: _____________________________ #:________________________________

I would like to set up direct billing for services: YES / NO

Referred by: ____________________________ Occupation: _______________________________________

MASSAGE PRESCRIBED by doctor: YES / NO

List any current medications and purpose:

____

____

____

Primary Complaint: ____

Pain Level (1- 10): Good Day __________ Bad Day ___________ Today ___________

Do you suffer from Chronic Pain? YES / NO

What Aggravates it: ____

Improves it: ____

What are your GOALS:

Today's treatment:____

Long Term: ____

What AREAS do you want to focus treatment on: ____

Client Name: ______________________________ Date: _____________

Have you had a professional massage before? YES/ NO

If so, for what condition: ____________________ Date: ______________ Frequency: _________

What pressure do you prefer?

☐ Light ☐ Moderate ☐ Deep

Are there any areas you do not want massaged? (Feet, face, abdomen, etc.) ______________________

Do you have difficulty lying on your front, back or side: YES / NO

If so, Explain: ____

Are you receiving any other treatment with any other Health Practitioners:

☐ Chiropractor ☐ Physiotherapy ☐ Acupuncture ☐ Other _____________

Please specify name(s) : ____

Reason: ____ Date: ______________ Frequency: _________

Do you have any Allergies? YES / NO Specify: ____________________________________

Do you have sensitivities to scents, lotions, oils? YES / NO Specify: ___________________________

Are you currently pregnant? YES / NO Due Date: _________________

Please check any of the following that apply to you:

☐ Bone/ Joint Disorder	☐ Autoimmune Disorder	☐ High / Low Blood Pressure
☐ Tendonitis/ Bursitis	☐ Spinal Problems	☐ Blood Clots
☐ Arthritis	☐ Heart Condition	☐ Lymphedema
☐ Lupus	☐ Varicose Veins	☐ Thrombosis/ Embolism
☐ Anxiety	☐ Depression	☐ Sleep Disorder
☐ Cancer	☐ Diabetes	☐ Heart Attack
☐ Headaches	☐ Neuropathy	☐ Stroke
☐ Digestive Disorder	☐ Fibromyalgia	☐ Numbness

Explain:

____

____

____

Client Name: ______________________________ Date: _____________

Current Activity Level (1 - 10): _________

- ☐ I sit for several hours a day
- ☐ I want to be more active
- ☐ I exercise regularly Type and frequency: ___________________________________
- ☐ I stretch regularly Frequency : ____

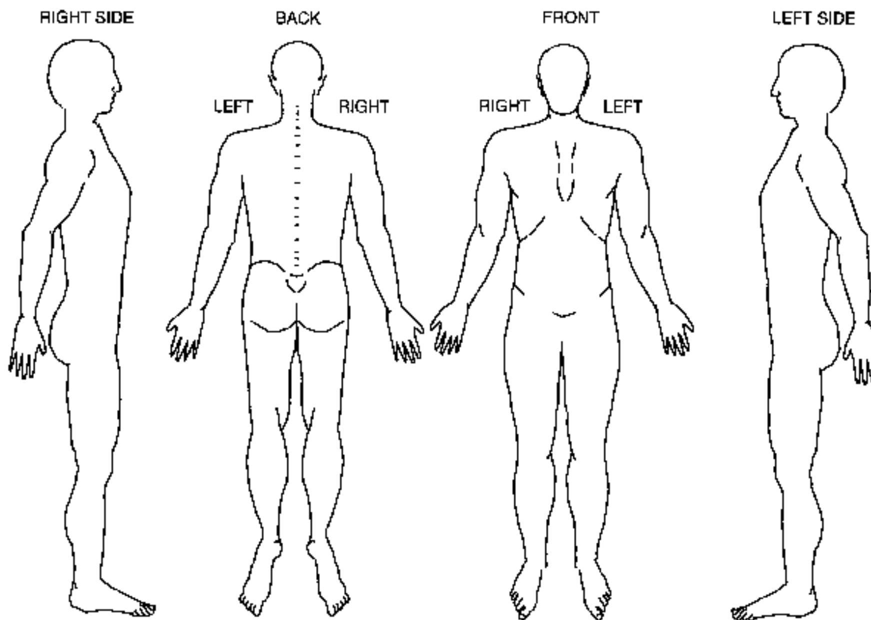
Does Pain affect your activity level? YES / NO

If so, Explain: ____

Does Pain affect any activities in your day to day life? YES / NO

If so, Explain: ____

Please put an “X” on areas of pain or discomfort and “N” in areas of numbness.



List any Injuries/accidents still affecting you:

____

____

____

Client Name: ______________________________ Date:____________

CONSENT TO PHYSICAL ASSESSMENT

In order to create a safe and effective treatment plan, a physical assessment is required. My massage therapist will be observing postural imbalances and touching areas of my body within my comfort level and/or performing orthopaedic assessment tests that may result in pain and tenderness. This can potentially aggravate your symptoms. Open communication is KEY and I agree that I will tell my massage therapist anytime I feel these symptoms in order to make sure I am being treated safely.

I, ____________________________(please print) understand and consent to a physical assessment as explained to me by my massage therapist. If I have any questions about my assessment or want the assessment to stop or modify I will instruct my practitioner accordingly.

Client Signature: ____________________________________ Date: ____________________

Therapist: ____ Date: ____________________

*** Please complete and email forms to Diana at touch_of_balance@hotmail.com.**

A Touch of Balance

Client Name: ______________________________ Date:__________

NOTES

LIST ANY OTHER INFORMATION OR QUESTIONS: