

# Renewal Therapeutic Massage

## Confidential Information & Health History

Date: \_\_\_\_\_ Where did you hear about us? \_\_\_\_\_

Full Name: \_\_\_\_\_ Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ email: \_\_\_\_\_

(mobile) \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Is this your first professional Massage? Circle Yes No

If no how frequently do you get a massage? Circle weekly monthly quarterly yearly Not often enough

Do you have any specific issues you would like to focus on today? \_\_\_\_\_

Are you currently under the care of a physician? Yes No Whom? \_\_\_\_\_

Have you had any accidents, injuries or surgeries in the past 5 years? Yes No If yes please describe below:

What is your pain level today on a scale of 0 being no pain and 10 being excruciating ? Please circle:

0 1 2 3 4 5 6 7 8 9 10

### Current Health

Do you exercise regularly and/or participate in any sports? Yes No

If yes what kind of exercise/sports \_\_\_\_\_

Do you perform any repetitive movement in your work, sports or hobby? Yes No

If yes describe \_\_\_\_\_

Do you sit for long hours at a workstation, computer or driving? Yes No

If yes specify \_\_\_\_\_

Do you experience stress in your work, family or other aspect in your life? Yes No

Are you experiencing tension, stiffness, discomfort or pain? Yes No

If yes describe \_\_\_\_\_

Have you recently had an injury, surgery, or areas of inflammation? Yes No

If yes describe \_\_\_\_\_

Do you have sensitive skin? Yes No

Do you have any allergies to oils, lotions, or ointments? Yes No Explain \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

List any known allergies \_\_\_\_\_

Are you currently experiencing any of these symptoms or conditions? Please check those that apply to you:

**Musculoskeletal**

- Bone or joint disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw Pain (TMJ)
- Lupus
- Spinal Problems
- Migraines/Headaches
- Osteoporosis

**Circulatory**

- Heart Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymphedema
- Thrombosis/Embolism

**Respiratory**

- Breathing Difficulty/Asthma
- Emphysema
- Allergies, specify: \_\_\_\_\_
- Sinus Problems

**Nervous System**

- Shingles
- Numbness/Tingling
- Pinched Nerve
- Chronic Pain
- Paralysis
- Multiple Sclerosis
- Parkinson' s Disease

**Reproductive**

- Pregnant, stage \_\_\_\_\_
- Ovarian/Menstrual Problems
- Prostate

**Skin**

- Allergies, specify: \_\_\_\_\_
- Rashes
- Cosmetic Surgery
- Athlete' s Foot
- Herpes/Cold Sores

**Digestive**

- Irritable Bowel Syndrome
- Bladder/KidneyAilment
- Colitis
- Crohn' s Disease
- Ulcers

**Psychological**

- Anxiety/Stress Syndrome
- Depression

**Other**

- Cancer/Tumors
- Diabetes
- Drug/Alcohol/Tobacco Use
- Contact Lenses
- Dentures
- Hearing Aids

Any other medical condition(s) not listed:

Please explain any of the conditions that you have marked above :

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The above information is true and accurate to my knowledge. I understand that massage therapists do not diagnose disease, prescribe medication, 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 agree to not hold my practitioner liable should I fail to do so. I understand that the massage I receive is provided with the basic purpose of relaxation and the relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure/strokes can be adjusted to my level of comfort. I also understand that cancelled or missed appointments without 24 hrs notice (medical emergencies excluded) will be charged in full for the price of missed session if it cannot be rebooked.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_