

Client Consultation- Massage



Date: ____/____/____

Name: _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? No Yes If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? No Yes

If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? No Yes

If yes, please explain _____

4. Do you have sensitive skin? No Yes

5. Are you wearing contact lenses No Yes / Dentures No Yes / Hearing aid No Yes

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

If yes, please describe _____

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

If yes, please describe _____

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

If yes, how do you think it has affected your health?

Muscle Tension No Yes / Anxiety No Yes / Insomnia No Yes / irritability No Yes / other _____

9. Is there an area of the body where you are experiencing tension, stiffness, pain or other discomfort? No Yes

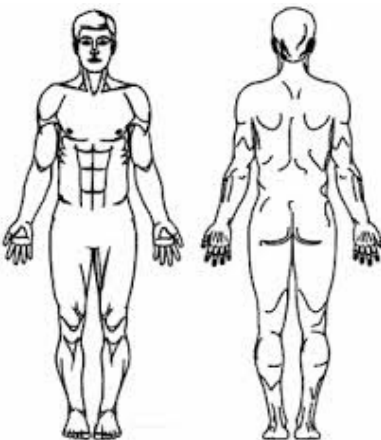
If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? No Yes

If yes, please explain _____

Medical History:

11. Circle any specific areas you would like the massage therapist to concentrate on during the session:



12. Are you comfortable with having massage on the following areas?

- Pectoral No Yes
- Scalp No Yes
- Face No Yes
- Abdomen No Yes
- Feet No Yes
- Gluteal No Yes

13. Are you currently under medical supervision? No Yes

If yes, please explain _____

14. Do you see a chiropractor? No Yes If yes, how often? _____

15. Are you currently taking any medication? No Yes

If yes, please list _____

16. Please check any condition listed below that applies to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> varicose veins | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> atherosclerosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> phlebitis | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> deep vein thrombosis/blood clots | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> joint disorder/rheumatoid | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> sprains/strains | arthritis osteoarthritis/tendonitis | <input type="checkbox"/> pregnancy / if yes, how many |
| <input type="checkbox"/> current fever | <input type="checkbox"/> osteoporosis | months? _____ |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> epilepsy | |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> headaches/migraines | |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> cancer | |

Please explain any condition that you have marked above _____

17. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 18.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Signature: _____ Date: _____

Massage Therapist: _____ Date: _____