

Advanced Soft Tissue Therapy, Inc. Massage Client History

- Name _____ Date _____
- DOB _____ Cell Phone _____ Work Phone _____
- Home Phone _____ Address _____
- City _____ State _____ Zip _____
- E-mail _____ Physician _____
- Significant Other _____ Phone _____
- Occupation _____ Referred by _____
- Height _____ Weight _____ Smoker? _____
- What are your goals for this treatment? Relaxation Stress Relief Pain Relief Other _____
- Where are you feeling pain or discomfort _____
- Physicians that you have seen for your current discomfort/pain _____
- Medical diagnosis _____
- At work I mostly do: Phone Computer work Lifting Sitting Standing Driving
- When was your last professional massage treatment? _____
- What kind of pressure do you prefer? Light Medium Firm Deep Tissue
- How often do you exercise? Daily Weekly 3-6 times per week 1-3 times per week
- How much time? 1-30 minutes 30 to 60 minutes Greater than 60 minutes
- What type of exercises or flexibility do you do _____

Please circle any of the following that apply to your condition currently or during the past year. Massage Therapy may be contraindicated unless prescribed because of some medical conditions

- | | | |
|--------------------------------|--------------------------|-------------------------------|
| Muscle spasms in neck | Limited range of motion | Contagious/infectious disease |
| Tightness in shoulder muscle | Constipation | Medications |
| Pain in shoulder (s) | Bladder trouble | Cancer |
| Pins and needles in hands/feet | Kidney trouble | varicose veins |
| Headaches | Prostrate problems | Swollen/painful joints |
| Whiplash | Pains in legs and feet | Skin disorders |
| Dizziness | Chest pain | Ulcers |
| Sciatica | Swollen ankles | Fractures |
| Numbness | Blood Clots/phlebitis | Bruising |
| Grating in neck | Low/high blood pressure | Difficulty breathing |
| Hernia | Cold feet or Cold hands | TB |
| Pinched nerve in back | Diabetes | Herniated or bulging disc |
| Broken Bones | Metal Implants or screws | Pacemaker |
| Injuries | Bruise Easily | Epilepsy or seizures |
| Allergies | Back Pain | Frozen shoulder |
| Pregnancy | Have on contact lenses | Wearing Dentures |
| Other conditions: | | |

I understand that the massage therapy that I receive is provided for the purpose of relaxation and relief of muscular tension. Discomfort and pain can occur with massage therapy treatments. I agree to immediately inform the massage therapist should I experience any pain or discomfort during this session, or future sessions, so that the pressure and/or strokes may be adjusted to my level of comfort. I take full responsibility for any discomfort that may occur from the massage and will hold the massage therapist harmless for any discomfort suffered. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe treatment for any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I affirm that I have stated all my known medical conditions and answered all questions honestly. I understand that massage therapy should not be performed when certain medical conditions exist, such as cancer, without physician approval. Therefore, I agree to keep the practitioner informed of my current medical condition.

I agree to give at least 24 hours notice to cancel an appointment. Should I fail to give this proper notice I agree to pay the full cost of the time booked.

Client Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize the massage therapist to administer massage therapy, to my child or dependent, as they deem necessary.

Signature of Parent or Guardian _____ Date _____

Please color in any area of discomfort

