IN TOUCH
massage, wellness & day spa

Massage Therapy Client History

Today's Date: _____

Name _____ Birthdate _____

Street _____ City _____ State _____ Zip Code _____

Phone (Business) _____ Phone (Home) _____ Phone (Cell) _____

Email Address _____

Physician Name _____ Address, City, State, Zip _____

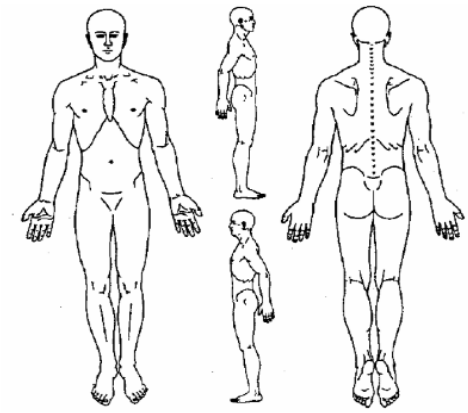
Auto or Work Claim? ☐ Yes Claim # _____

Occupation _____ Referred By _____

Reason for visit today? _____ Prior massage therapy? ☐ Yes

Are you in pain? Please indicate:

No Pain
0
1
2
3
4
5
Severe



How would you describe your general health?

Recent test/screenings (e.g.: Blood, X-ray, MRI)? ☐ Yes

Medications and supplements? (Please Print & List):

Are you physically active? ☐ Yes Sleep Well? ☐ Yes

Women – Pregnant? ☐ Yes Trimester? 1 2 3

Symptoms/Conditions – Please indicate:
C – Current P – Past F – Family history

_____ Signs of inflammation or infection
_____ Tension headaches or migraines
_____ "Pins & needles" or numbness
_____ Strength or sensory loss of any kind
_____ Hearing or vision loss, balance/coordination
_____ Cardiovascular disease. Pacemaker ☐ Yes
_____ High or low blood pressure
_____ Diabetes, or other hormone disorders
_____ Broken bones, artificial joints, bone disease
_____ Osteo- or rheumatoid arthritis, bone disease
_____ Cuts, warts, open sores, skin irritation
_____ Bronchitis, emphysema or asthma
_____ Tuberculosis, hepatitis, herpes or HIV
_____ Allergies, hyper-sensitivities, anaphylaxis
_____ Cancer or auto-immune disorder
_____ Multiple sclerosis, epilepsy, nerve disorder
_____ Anxiety, panic attacks or mood disorder
_____ Other medical conditions not listed

How do your symptoms affect your recreation, work duties and social interaction?

Please list nature and date of surgeries or severe trauma:

Other therapies/treatments currently receiving?

"I understand my information is held private and confidential and release only with my permission or as required by law." If you agree, please sign and date:

Name: _____ Date: _____

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Client Communication Instructions

Client Name: _____ DOB: _____

May your therapist or staff member call your residence and leave a massage with any person answering the phone if you are unavailable?

YES NO _____ (Home Phone Number)

May your therapist or staff member call or text your cell phone if applicable? If YES, please provide the number.

YES NO _____ (Cell Number)

May your therapist or staff member send an email if applicable? If YES, please provide the address.

YES NO _____ (Email Address)

May your therapist or staff member call your place of employment and leave a message with any person answering the telephone if you are unavailable? If YES, please provide the number.

YES NO _____ (Office Phone Number)

Under HIPAA guidelines, your medical information may be released to another provider or healthcare facility to ensure that best possible care during the course of your treatment.

Please provide below if there is a spouse or other person whom you would like to authorize disclosure and/or release of your medical/billing information.

Name: _____ DOB: _____ Phone: _____

Name: _____ DOB: _____ Phone: _____

Date: _____ Client or Legal Guardian: _____