



Massage Therapy

by Zach Stahlecker, CMT

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY FOR CHAIR MASSAGE

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (h): _____ (c): _____

Birth Date: ____ / ____ / ____ Email Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Please check if you have had any of the following: Is this your first professional massage? Yes No

Arthritis, Tendonitis Headaches/Migraines

If no, how often do you receive massage? _____

Cancer, Tumours Allergies/Sensitivities

Please list current medication:

TMJ Problems Skin Conditions

Varicose Veins Neck/Back Injuries

Pregnancy Heart Problems

Blood Clots Joint Problems

Epilepsy Circulation Problems

Do you have any ongoing or chronic pain? Explain:

Diabetes Low Blood Pressure

Paralysis High Blood Pressure

Fibromyalgia Major Accident

Numbness Recent Injuries

Sprains, Strains Other _____

Is there anything you would like to discuss today?

Explain any condition you have marked above:

I understand the benefits and risks of massage and give my consent for massage. It is also understood that the massage practitioner has the right to refuse service to anyone. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes. I understand that the purpose of this massage is to reduce stress and increase relaxation. I will immediately inform the practitioner so that pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork 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 I am aware of.

Sign: _____ Date: _____