



MASSAGE THERAPY INITIAL ASSESSMENT

Your answers to the following questions will be kept confidential. They will be seen only by the therapist(s) with whom you choose to work and have requested so that we may provide you with better care.

Name _____ Date _____

Address _____ Phone (day) _____

Phone (eve) _____

Age _____ Sex: M F Pregnant: Y N Do you wear contacts or Hearing Aid? Y N

Birthday ___/___/___ Anniversary ___/___/___ Spouse's Name _____

Occupation _____ What do you do for exercise? _____

What do you do for relaxation? _____

What other recreation activities do you spend time on? _____

Have you received massage previously? _____ How did you hear of us? _____

Reason(s) for receiving a massage:

- Relaxation/Stress Reduction
- I just like it...
- Pain/Injury
- Increase Body-Awareness
- Integration of Body-Mind Emotions
- Other _____

What kind of pressure do you prefer? : Deep Medium Light

Please list any major traumas you have had to your body (e.g. auto accident, falling, etc.) _____

Do you currently, or have you recently had any of the following?

Please mark and include all muscle, bone or joint injuries (even if not recent):

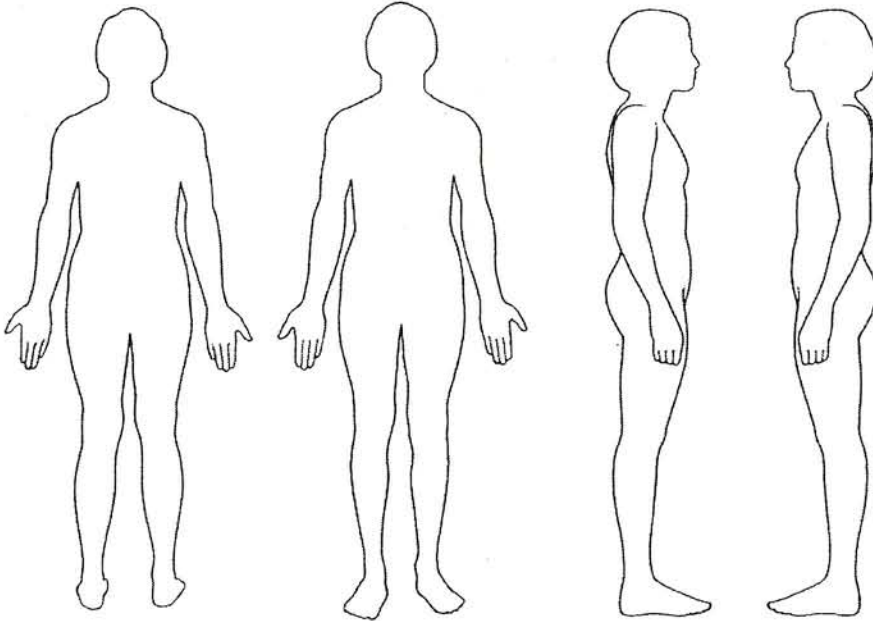
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Severe cuts, wounds |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Skin conditions, rash |
| <input type="checkbox"/> Blood clots/Phlebitis | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> HIV/AIDS/ARC | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Spinal Fusion |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Loss of muscle function | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Muscle strain or tear | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness | <input type="checkbox"/> Terminal diagnosis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Paralysis/Spasticity | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Contagious Conditions | <input type="checkbox"/> Heal unusually slowly | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> Scoliosis |

Allergies (inhalant, food or contact) _____

Drugs taken in last two weeks (prescription & recreational) _____

Client Record

Please mark areas of pain, discomfort or significant sensation/lack of sensation the diagrams below:



Areas you would like worked on:

- Back
- Neck
- Arms
- Legs
- Feet
- Hands
- Other

In the last three years, have you received care from any other health professionals (e.g. Chiropractor, Surgeon, Therapist, etc.)?

- Yes No
-

Practitioner's name	Practitioner's field (e.g. dentistry, chiropractic)	Place of work	Phone
1)			
2)			
3)			

Is there any other information that you feel I should be aware of? _____

The following sometimes occur during massage:

- *Movement or release of intestinal gas* **Crying, laughing*
- *Strong emotions* **Sighing, groaning, yawning* **Softening of muscle tissue* **Stomach gurgling*
- *Cognitive or felt memories* **Need to move or change position* **Energy shifts*

These are normal responses to relaxation and/or touch, and you need not be embarrassed nor suppress them. At any time during your session, please let me know if there is anything I can do to help you feel more comfortable.

I understand that the services provided are not a replacement for medical or psychological care and that any information provided is not prescriptive or diagnostic in nature and is for educational purposes only. I also give my permission for the LMT(s) with whom I work to discuss information pertinent to my condition(s) and treatment, with my other health care providers.

Client signature

Date

Signature of Licensed Massage Therapist: _____