617.719.7476

LMT
JOHN DAVIS
therapeutic massage

recover
relax
reclaim

Client Health History

Print clearly and complete both sides of this form. This information is critical to your treatment as it may affect the manner in which your therapist structures your session. All information disclosed is kept strictly confidential.

Please note: Clients who are pregnant, currently undergoing cancer treatment, have acute injuries or medically complex conditions, or have pending litigation and/or insurance claims should notify your therapist.

Email _____ This will be used only to inform you of promotions and health information

How did you hear of us? _____

Name _____ Date _____

Address _____
Street City State Zip

Home phone _____ Work phone _____

Male / Female Date of birth _____ Occupation _____

Have you ever had a therapeutic massage before? Yes No Many Times

What is the amount of tension in your life? 0 ....1 .....2 .....3 .....4 .....5 .....6 .....7 .....8 .....9 10
none average extreme

What physical activities do you do on a daily or weekly basis? _____

Please circle any painful or tense areas as well as regions that you tend to hold your stress:

Head/face Low back Shoulders Neck Abdomen Legs/feet Arms/hands Mid-back

Other (please describe) _____

Does your stress/pain limit your daily or recreational activities in anyway? (please describe)

Are you currently under a physician's care? Yes / No (If Yes, for what condition?) _____

List medications you take: (including pain reliever, other non-prescription drugs, and herbal remedies)

Please circle any of the following health issues that you have had in the past year.

Allergies: (list) _____

Angina	Fibromyalgia	Irritable Bowel Syndrome	Stroke
Asthma	Heart disease	Insomnia	Surgery
Blood clot	Hepatitis	Migraines/Headaches	Varicose veins
Cancer	Herpes simplex	Phlebitis/Thrombosis	Whiplash
Carpal Tunnel Syndrome	Hospitalization	Pregnancy	Other:
Communicable diseases	Hypertension	Repetitive Strain Injuries	
Disk problems	Immune system conditions	Sciatica	

Client: Please continue on the other side.

For therapist use. List client preferences, supports, positioning, table height, etc.

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General Medical Signs and Symptoms. Please indicate if you *currently* have any of the following conditions.

	Symptom	Yes	No	Location: Please describe
1	Any areas of infection?			
2	Any areas of swelling, edema or tendency to swell?			
3	Any areas of numbness or altered sensation?			
4	Any areas of pain or tenderness?			

Specific Medical Conditions. Therapeutic massage may affect these and your health. For your safety, our therapists must be aware of ***all medical conditions***.

	Condition	Yes	No	Please Describe
5	Arthritis			
6	Cancer or Tumors			
7	Cardiovascular Diseases			**Please circle all that apply: anemia, angina, arteriosclerosis,** congestive heart failure, heart attack, heart murmur, hemophilia, hypertension, varicose or spider veins, other (please describe):
8	Diabetes			
9	Injuries			
10	Kidney, Liver or Urinary problems			
11	Respiratory Conditions			
12	Skin Conditions			**Please circle all that apply: acne, abrasions/cuts,** birthmarks/moles, bruises, dermatitis, eczema, herpes, hives, poison ivy/oak/sumac, psoriasis, skin tags, sunburns, warts, other (please describe):
13	Surgery			Date of Surgery: Describe:
14	Gastrointestinal Problems			
	Other Medical Conditions **not** mentioned above			

Please read and sign:

I verify that all information provided is correct and current to the best of my knowledge. I understand that any information provided by the therapist is for educational purposes only and is not prescriptive or diagnostic in nature. I hereby give my consent to receive therapeutic massage and will not hold my therapist responsible for any personal injury or loss of property.

Signature _____ Date _____