

Client Health Information Sheet

Name: _____ Date: _____

Present symptoms: What is your major complaint or condition you want to improve? _____

When did you first notice major complaints? _____

What brought it on? _____

What activities aggravate the condition? _____

Is this condition getting progressively worse? No Yes

Please explain: _____

Does this condition interfere with work? N Y Sleep? N Y Daily Routine? N Y

Please explain: _____

What have you done to get relief? _____

Has there been a medical diagnosis? No Yes (if yes, by whom?) _____

Please Explain: _____

Have you had X-rays taken? No Yes (if yes, by whom?) _____

List any current medications: _____

List any allergies: _____

Please check any of the following conditions that apply to you, past and present.

Skin problems Arthritis High/low blood pressure

Blood clots Diabetes Varicose veins

Seizures Cancer Contagious diseases

Contact lenses Circulation disorders Pregnant (or trying to)

Add any additional information on these issues here: _____

(continued on other side)

Please list (date and description) any accidents and operations, and other major life trauma: ___

Describe the exercise activities you do (include frequency): _____

List other therapies you receive: _____

Please list any additional comments regarding your health and well-being: _____

What are your intentions or expectations for this visit? _____

On these diagrams please **circle** the areas of your body that need the most attention in the massage session, and place an **x** over the areas that you wish to have avoided.

