

The Teal Center for Therapeutic Bodywork, Ltd.

CLIENT INFORMATION

Please print

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Phone number

Occupation \_\_\_\_\_ Birth Date \_\_\_\_\_ Referred by \_\_\_\_\_

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Have you had professional massage before? \_\_\_\_\_ If so, what kinds? \_\_\_\_\_

What are you looking for in your massage today? Relaxation \_\_\_\_\_ Pain Relief \_\_\_\_\_  
Injury Rehabilitation \_\_\_\_\_ Other \_\_\_\_\_

What are your primary areas of pain, discomfort or tension? \_\_\_\_\_

How long have you had this discomfort? \_\_\_\_\_

What do you think is the cause of this discomfort? \_\_\_\_\_

Have you had previous treatment for this discomfort? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

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Are you presently under a doctor's or therapist's care? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, for what? \_\_\_\_\_

Physician's or therapist's name \_\_\_\_\_

Please list any medications you are taking and what they are for \_\_\_\_\_

Rate your normal stress level: 1(low) to 10 (high) \_\_\_\_\_ Rate your current pain level: 1-10 \_\_\_\_\_

Rate your general health: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ If so, to what? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Do you wear contact lenses? \_\_\_\_\_ Do you take supplements? \_\_\_\_\_ If so, which ones? \_\_\_\_\_

What do you do for exercise, and how often? \_\_\_\_\_

Over please

(Females only) Are you pregnant? \_\_\_\_\_ If so, when is your due date? \_\_\_\_\_  
Have you had any complications? \_\_\_\_\_ Obstetrician's name: \_\_\_\_\_

Please circle any of the following conditions which you currently have or have experienced in the past.  
Some may be contraindications for massage.

Systemic Infections: \_\_\_ Mononucleosis \_\_\_ Flu \_\_\_ Hepatitis \_\_\_ Fever \_\_\_ Other \_\_\_\_\_

Cardiovascular: \_\_\_ Varicose veins \_\_\_ Stroke \_\_\_ Acute inflammation  
\_\_\_ Phlebitis \_\_\_ High blood pressure \_\_\_ Heart attack  
\_\_\_ Blood clots \_\_\_ Low blood pressure \_\_\_ Heart disease

Skin infections: \_\_\_ Eczema \_\_\_ Burns \_\_\_ Other \_\_\_\_\_

Musculo-Skeletal: \_\_\_ Neck pain or stiffness \_\_\_ Low back pain \_\_\_ Sports injuries: \_\_\_\_\_  
\_\_\_ Shoulder pain \_\_\_ Hip pain/sciatica \_\_\_ Fractures: \_\_\_\_\_  
\_\_\_ Upper back pain \_\_\_ Knee pain \_\_\_ Sprains/strains: \_\_\_\_\_  
\_\_\_ Arm pain \_\_\_ Leg pain \_\_\_ Torn ligaments/cartilage/tendons  
\_\_\_ Hand pain \_\_\_ Foot pain \_\_\_ Whiplash  
\_\_\_ Carpal tunnel \_\_\_ Scoliosis \_\_\_ Arthritis \_\_\_ Fibromyalgia  
\_\_\_ Other RSI: \_\_\_\_\_ \_\_\_ Osteoporosis \_\_\_ TMJ dysfunction/jaw pain  
\_\_\_ Tension headaches \_\_\_ Migraines \_\_\_ Tinitis/ringing in ears

Neurological: \_\_\_ Disc disease \_\_\_ Numb, weak or cold extremities \_\_\_ Twitches/jumpiness  
\_\_\_ Seizures \_\_\_ Chronic Fatigue Syndrome \_\_\_ Other \_\_\_\_\_

Endocrine: \_\_\_ Diabetes \_\_\_ Hypoglycemia \_\_\_ Other \_\_\_\_\_

Respiratory: \_\_\_ Emphysema \_\_\_ Hay fever \_\_\_ Asthma \_\_\_ Other \_\_\_\_\_

Reproductive: (Females) \_\_\_ Menstrual cramps \_\_\_ PMS \_\_\_ Other \_\_\_\_\_  
(Males) Prostatitis Other \_\_\_\_\_

Digestive: \_\_\_ Constipation \_\_\_ Diarrhea \_\_\_ Colitis \_\_\_ Crohn's disease \_\_\_ Other \_\_\_\_\_

Psychiatric: \_\_\_ Mood swings \_\_\_ Sleep disorders/insomnia \_\_\_ Exhaustion \_\_\_ Depression  
\_\_\_ Acute anxiety \_\_\_ Panic disorder \_\_\_ Other \_\_\_\_\_

Please describe any past surgeries, automobile accidents, serious falls, or other injuries and include dates.

\_\_\_\_\_

Please describe any diagnosis of cancer, including date of diagnosis and type of treatment. \_\_\_\_\_

\_\_\_\_\_

Is there anything else I should know about you, your health, or your body before administering massage therapy? Please describe: \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_