Arrendale's Massage

Personal information

name date of birth

address

city state zip

Preferred phone

email

occupation employer

marital status spouse's name

emergency contact name, relationship phone

Preferred appointment reminder: Call Text Email
(circle one)

Massage Experience

Have you had a professional massage before? Y N

What are your goals for treatment? _____

How did you hear about us?_____
Please tell us their name/address so we can thank them!

Current Health

Do you exercise regularly and/or participate in sports? Y N
If yes, describe _____

Do you perform any repetitive movement for work or hobby? Y N
If yes, describe _____

Do you sit for long hours at a computer or driving? Y N
If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? Y N
If yes, describe _____

Have you recently had an injury, surgery or areas of inflammation? Y N
If yes, describe _____

Do you have sensitive skin? Y N

Do you have any allergies to oils, lotions, ointments or other products? Y N
If yes, describe _____

List any medications you are currently taking:

_____

_____

Health History

Musculoskeletal
- ☐ Bone or joint disease
- ☐ Tendonitis/Bursitis
- ☐ Arthritis/Gout
- ☐ Jaw Pain (TMJD)
- ☐ Lupus
- ☐ Spinal Problems
- ☐ Migraines/Headaches
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis

Circulatory
- ☐ Heart Condition
- ☐ Phlebitis/Varicose Veins
- ☐ Blood Clots
- ☐ High/Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis/Embolism
- ☐ Dizziness/Fainting
- ☐ Swollen Ankles

Skin
- ☐ Allergies, specify:

_____
- ☐ Rashes
- ☐ Cosmetic Surgery
- ☐ Athlete's Foot/Fungal
- ☐ Herpes/Cold Sores

Respiratory
- ☐ Breathing Difficulty/Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Allergies, specify:

_____
- ☐ Sinus Problems

Nervous System
- ☐ Shingles
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ Chronic Pain
- ☐ Paralysis
- ☐ Parkinson's Disease/MS/MD
- ☐ Stroke
- ☐ Cerebral Palsy
- ☐ Brain/Spine Injury

Reproductive
- ☐ Pregnant, stage
- ☐ Ovarian/Menstrual Problems
- ☐ Prostate

Digestive
- ☐ Irritable Bowel Syndrome
- ☐ Bladder/Kidney Ailment
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers

Psychological
- ☐ Anxiety/Stress Syndrome
- ☐ Depression
- ☐ Forgetfulness
- ☐ Trouble Concentrating

Other
- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Drug/Alcohol/Tobacco Use
- ☐ Contact Lenses
- ☐ Dentures
- ☐ Hearing Aids
- ☐ Fibromyalgia

Any other medical condition (s) not listed:

_____

_____

Please explain any condition that you have marked :

_____

_____

Client agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. Kindly give 24 hours notice if cancellation is needed. No shows will be charged full session price for missed session.

_____

Client Signature *date*