DONNA'S MASSAGE THERAPY - CLIENT PROFILE

Name: _____ DOB: _____ Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Work Responsibilities: _____

Primary Care Provider: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

CURRENT HEALTH *(Circle Applicable Items)*

Have your received massage therapy before? Yes No Frequency: _____

Reason for today's visit: _____ Primary Goal: _____

Is Your Concern: Minor Problematic Major Recurring Getting Worse Getting Better

Have you had this concern/goal previously? Yes No Frequency: _____

Have you received treatment previously? Yes No Frequency: _____

Current Medications/Treatment Modalities: _____

Any applicable conditions? Pregnancy Heart Issue Circulatory Issue Blood Clots Diabetes Infections Cancer Arthritis Respiratory Issue

Explanation: _____

Is there anything I should know to ensure your comfort regarding: Oils Lotions Scents Detergents Foods Animals Other _____

Explanation: _____

Contact Lenses? *(The face pillow may put pressure on your eyes)*

Hearing Disability? *(Communication is helpful during the session)*

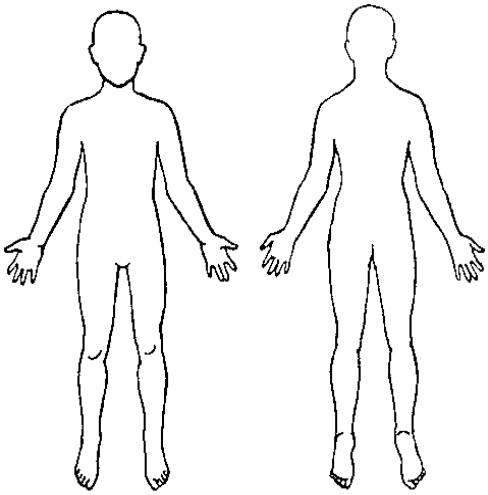
Hair/Make-Up, Clothes (Will you return to work after your session?) Yes No

Movement Abilities? (i.e. Getting on/off table, pillows, etc.)

Please circle areas of today's concern on the images at right →

RATE SEVERITY OF ALL SYMPTOM AREAS FROM 1-10

(1=I feel like a newborn baby! – 10=Please put me out of my misery!)



PREVIOUS MEDICAL HISTORY

(List in chronological order, give dates (or ages), and treatment received)

Surgery: _____

Accident: _____

Major Illness: _____

CONSENT FOR CARE

It is my choice to receive massage therapy. I am aware of the benefits and possible risks of massage and hereby give my consent for treatment. I understand that there is no implied or stated guarantee of success or 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 immediately.

Signed: _____ Today's Date: _____