

MASSAGE HEALTH HISTORY

Name: _____ D.O.B. _____ Age: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Best Number To Reach You: Cell Work Phone: _____ Email*: _____
Cell Phone Carrier to receive appointment reminder via text messages: _____
Occupation: _____ Activities at work: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

***Your email is confidential and never sold. By sharing your email you will receive appointment confirmations and a monthly FitBody Studio specials & health tips.**

How did you hear about us? _____

1. Why are you coming for massage? _____
2. Do you want a full body massage? _____ List any specific areas that need focus? _____
3. Please select any of the following that might apply:

- | | |
|--|--|
| <input type="checkbox"/> Allergies, which: _____ | <input type="checkbox"/> Open sores, where: _____ |
| <input type="checkbox"/> Arthritis, where: _____ | <input type="checkbox"/> Phlebitis/Blood Clots, where: _____ |
| <input type="checkbox"/> Cancer __ Current; __ Latent. Type: _____ | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnant, what month? _____ |
| <input type="checkbox"/> Diseases/Current Diagnosis: _____ | <input type="checkbox"/> Recent Change in Weight |
| <input type="checkbox"/> Edema, where: _____ | <input type="checkbox"/> Respiratory Condition: _____ |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin Condition: _____ |
| <input type="checkbox"/> High Blood Pressure/Heart Condition | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Infectious Condition: __ HIV __ TB __ Shingles | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Medications: _____
(use back of form to list additional medications) | <input type="checkbox"/> Wear Contacts |

4. Please explain recent or past accidents/injuries/surgeries/diagnosis? (use back of form to list additional)

A) Explain: _____
_____ When? _____

Have you had any of the following symptoms since the explained incident?

- | | | |
|--|---|---|
| <input type="checkbox"/> Blurred/Double Vision | <input type="checkbox"/> Swelling, where: _____ | <input type="checkbox"/> Ringing in Ear |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Trouble Talking | <input type="checkbox"/> Headache |

5. What are your current stress/tension factors? _____

6. What are your exercise habits? What type of activities? _____
_____ How often per week? _____

7. Massage Therapy Information

- a) Last date you received a massage? _____
- b) Massage Therapy Preference: ___ Relaxation (Swedish) ___ Relaxation w/Therapeutic Pain Relief
- c) Pressure: ___ Light ___ Moderate ___ Deep

I certify that the above information is complete and correct. I will keep the massage therapist informed of any changes as they occur. I will be responsible for financial payments and for any scheduled appointment, which is not canceled 24 hours in advance. I understand that neither the therapist nor FitBody, LLC will be liable for any injuries or loss sustained to myself or property. In addition the therapist and staff disclaims responsibility for injury sustained during exercises or stretches given to perform. I will not begin exercises or stretches without first consulting my physician for advice.

Client Signature: _____ Date: _____

Notes: