CLIENT HISTORY

Shelly Peters-Schaller CMT, CCMT, CEMT

Client's Name:_____Birthday_____

Address:_____ City:_____ State:_____Zip:_____

Phone: Home:_____Work:_____Cell:_____

Email Address:_____

Occupation:_____Emergency Contact:_____

Health History

Have you seen a doctor for any reason in the last six months? Yes No

If yes what for?_____

_____

Are you currently taking any medications? Yes No

If yes what for?_____

_____

Please list all surgeries and hospitalizations with approximate dates:_____

_____

Please circle any of the following conditions which you are *currently* experiencing, and underlined the conditions you have experienced any time in the past.

Back Pain	Neck Pain	Shoulder Pain	Hand/Arm Pain	Foot/Ankle Pain
Knee pain	Arthritis	Tingling/Numbness	Fibromyalgia	Headaches
Cancer	Diabetes	Kidney Disease	Heart Disease	Herniated Disc
Anxiety	Depression	Insomnia	High Blood Pressure	High Stress
Diarrhea	Constipation	Tuberculosis	Digestive Disorder	Blood Clots
Asthma	Herpes	Skin Rash	Sinusitis	Fatigue
Athletes Foot	Ulcer	Bruise Easily	Allergies(nuts, oils?)	Epilepsy

Contagious disease:_____Muscle soreness (where?):_____Pregnant? (Due date:)

Do you take any of the following?

Tobacco/day:_____Alcohol/week:_____ __coffee/caffeine (cup/day):_____

Do you feel like you're coming down with anything today?_____

Do you have any artificial joints or pins in your body? _____Where?_____

Is there any other medical information and/or personal information you feel I should be aware of in order to provide you with the appropriate care?_____

(Over)

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Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated on my known medical conditions, and answered all questions honestly. I agreed to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I forget to do so. I understand this is a strictly therapeutic massage treatment and any direct or indirect sexual advance will result in immediate termination of the treatment without refund. I agreed to pay for the full amount of time I have scheduled. I agreed to cancel any prescheduled appointments at least five hours in advance or paid $35.00 cancellation fee.

Signature_____ **Date**:_____

(Over)