# Back In Motion Massage Therapy

**Confidential Client Case History**

In order to maximize the effectiveness and safety of massage sessions together, please take the time to carefully fill out this questionnaire. Use back of page if extra space is needed. **Please feel free to ask any questions, regarding your massage.**

NAME: _____ HOME #: _____

ADDRESS: _____ WORK#: _____

CITY: _____ STATE: _____ ZIP: _____ CELL #: _____

DATE OF BIRTH: _____ OCCUPATION: _____

SOCIAL SECURITY #: _____-_____-_____ PRIMARY DOCTOR: _____

HOW WERE YOU REFERRED: _____

In Case of Emergency Contact: _____

Emergency Contact Phone: _____ Relationship: _____

Marital Status: _____ Spouse's Name: _____

Have You Ever Received A Professional Massage? Y____ N____ If So, How Often? _____

What type of massage do you enjoy: ☐ Light Pressure ☐Medium Pressure ☐ Deep Pressure ☐You Can NEVER Go Too Deep

E-Mail Address: _____

**MEDICAL HISTORY**

Are you currently experiencing any of the following conditions?

___ Flu or Cold ___ Inflammation ___ Fever ___ Infection ___ Contagious Disease

Please check any of the following conditions that currently affect you or that you have experienced in the last 3 years:

| | | | |
|---|---|---|---|
| __ Headaches | __ High Blood Pressure | __ Cancer | __ Seizures |
| __ Neck Pain | __ Low Blood Pressure | __ Diabetes | __ Pregnancy |
| __ Shoulder/Arm Pain | __ Heart Disease | __ Dizziness/Fainting | __ Hepatitis A B C |
| __ Mid Back Pain | __ Blood Clots/ Phlebitis | __ PMS/Painful Menstruation | __ Immune Disorders (HIV/AIDS) |
| __ Low Back Pain | __ Varicose Veins | __ Osteoporosis | __ Neuritis |
| __ Hip/Leg Pain | __ Multiple Sclerosis | __ Osteoarthritis/Rheumatoid Arthritis | __ Anxiety/Panic Attacks |
| __ Sciatica | __ Stroke | __ TMJ | __ Ulcers |
| __ Disc Problems | __ Arthritis/Bursitis | __ Fibromyalgia | __ Plantar Fascitis |
| __ Whiplash | __ Numbness/Tingling | __ Difficulty Breathing | __ Athletes Foot |
| __ Anemia | __ Hemophilia | __ Raynauds Disease | __ Other _____ |
| __ Open Wound/Sore | __ Rashes | __ Warts/Moles | __ Other _____ |

What do you hope to accomplish from today's massage? _____

_____

Are you aware of any tension holding spots in your body? Y___ N___

If yes, location(s):_____

_____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

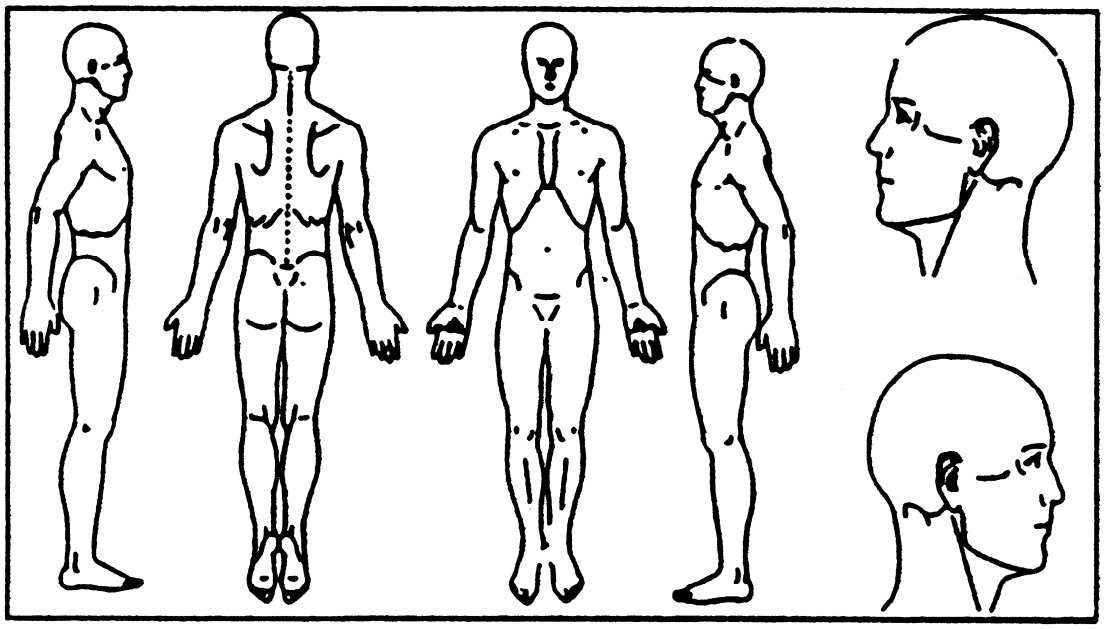
Over --->

Are you currently taking prescription medication? Y____ N_____
If yes, what? _____
Are there specific aspects of your life which are particularly stressful? (job, posture, habits, diet, family, etc.?)_____

**HABITS**

Do you exercise? Y____ N_____ How often? _____ Consume caffeine? Y____ N_____ Alcohol? Y____ N_____
Take non-prescription medications? Y____ N_____ What type?_____
Consume tobacco? Y____ N_____ If yes, (Either smoking or chewing) _____
How many hours do you sleep each night? _____ Bowel patterns? Regular or Irregular
Posture assumed most of the day? _____
Any other recent injuries? Y____ N_____ If so, when _____ Describe: _____
Do you wear dentures? Y____ N_____ Hearing Aids? Y____ N_____ Contacts? Y____ N_____

**PLEASE SHADE IN WHERE YOU EXPERIENCE PAIN ON THE DRAWING BELOW**



**WAIVER OF LIABILITY**

I understand that massage therapy given here is for the purpose of stress reduction, muscular tension or spasm relief, and/or increasing circulation.
I understand that the Massage Therapist at Back In Motion Massage does not diagnose illness, disease, or any other physical or mental disorder. As such, the Massage Therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. It has been made very clear to me that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I may have.
I have stated all my known medical limitations and do take it upon myself to keep the Massage Therapist in Back In Motion Massage Therapy updated on my physical health. I realize the therapist is not responsible for any contraindications for massage not given as history or prior to massage.
The Massage Therapist in Back In Motion Massage reserves the right to refuse service to anyone and refer him or her to a physician before being considered for treatment.

_____ _____
Client Signature Date