designing fitness
physical therapy
Therapeutic exercise and massage for lifelong wellness

Client Information

Name:_____ Age:_____
Address:_____
City:_____State:_____Zip Code:_____
Telephone:_____
Email address:_____
Referred by:_____
Emergency Contact:_____Telephone:_____
Primary Care Provider:_____Telephone:_____
Occupation/Hobbies:_____
Have you received a professional massage before?_____If so, how recently?_____
Ok to send periodic emails regarding therapeutic massage services? Yes No

Medical History

Are you currently seeking medical treatment for a particular problem? Yes No
If so, please elaborate:_____
Please check below if you have any of the following conditions:

____arthritis/joint pain
____osteoporosis
____bursitis/tendonitis
____gout
____broken/fractured bones
____sprains/strains
____low back/hip/leg pain
____neck/shoulder/arm pain
____headaches/head injuries
____jaw pain/TMJ
____high/low blood pressure
____neurological disease/issues
____cardiac or pulmonary condition
____infectious disease (TB, HIV, AIDS, Hepatitis)
____anticoagulant use/bruise easily
____warts
____rash
____athletes foot
____sinus problems/allergies
____herpes/shingles
____chronic pain/chronic fatigue
____dizziness/vertigo
____diabetes
____depression
____pregnancy
____epilepsy/seizures
____blood clots
____varicose veins
____sleep disorder
____high/frequent stress
____other disease:_____
____Allergies:_____
____Recent surgery:_____Date of surgery:_____
____Cancer:_____Date of diagnosis:_____
Please check if in treatment:____Chemo____Radiation____Hormonal____other

Therapeutic Massage Information

Do you have any areas of soreness or tension?

_____

Do you have any areas especially sensitive to touch?

_____

Do you have any areas of numbness or tingling?

_____

Is there an area you would like to concentrate on today?

_____

Are there any areas you would NOT like to have massaged today?

_____

Please circle the areas for which you give permission to receive massage:

back neck head face legs buttocks arms chest

I understand that the therapeutic massage I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my comfort level. Because massage should not be performed under certain medical conditions, I affirm that I have stated all known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated with any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that massage is not a substitute for medical examination, diagnosis, or treatment.

Client Signature:_____Date:_____

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