PERSONAL CLIENT RECORD

Date: ____________________________

Chambers Massage Therapy

Name: ____ Home Phone: ___________________________

Address: ____

City: _________________________________ State: ______________________ Zip: _______________________

Occupation: ____ Business Phone: _________________________

Sex::___________________DOB:_____________________ Age:_______________ Cell Phone:_____________________

In Case of Emergency:_________________________________ Phone: _______________________________

How did you hear about us? _________________________ Primary Care Physician: ________________________

Are you under the care of a physician now? ___________________ Physician's Name: ______________________

Have you ever had a professional massage before? ____

Are there specific aspects of your life that are particularly stressful? (job, posture, habits, diet, family, etc.) _______________

Explain: ____

Primary reason for appointment: ____

When did you first notice major complaint? ____

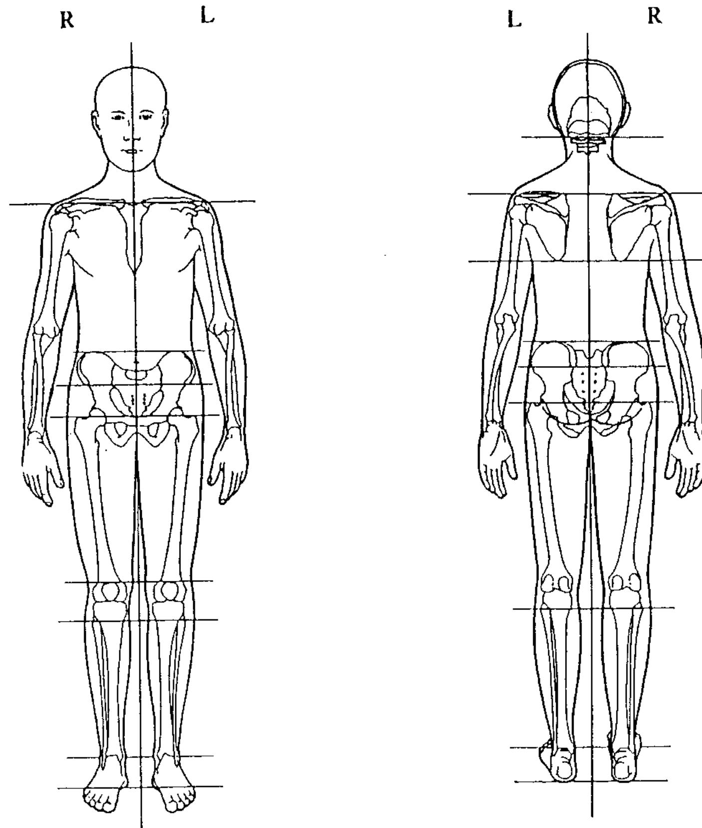
What brought it on? ____

Circle services that you are interested in: Relaxation Massage Deep Tissue Massage Neuromuscular Therapy Clinical Massage Hot Stone Massage Pregnancy Massage

HEALTH / FITNESS SURVEY

Height: ________________ Weight: __________________

PLEASE CIRCLE AREA WHERE PAIN IS LOCATED:



HEALTH HISTORY:

MUSCULO-SKELETAL
_______ bone or joint disease
_______ tendonitis
_______ bursitis
_______ broken/fractured bones
_______ arthritis
_______ sprains/strains
_______ low back, hip, leg pain
_______ neck, shoulder, arm pain
_______ headaches/head injuries
_______ spasms/cramps
_______ jaw pain/TMJ
_______ lupus
_______ herniated disc
_______ other

CIRCULATORY
_______ heart condition
_______ varicose veins
_______ blood clots
_______ high blood pressure
_______ low blood pressure
_______ lymphedema
_______ breathing difficulty
_______ sinus problems
_______ allergies
_______ other

INFECTIOUS DISEASE
_______ disease name(s):_______________________________________
____
____

SKIN
_______ allergies
_______ rashes
_______ athletes foot
_______ warts
_______ other

DIGESTIVE
_______ constipation
_______ gas/bloating
_______ diverticulitis
_______ irritable bowel syndrome
_______ other

NERVOUS SYSTEM
_______ herpes/shingles
_______ numbness/tingling
_______ chronic pain
_______ fatigue
_______ sleep disorders
_______ others

REPRODUCTIVE
_______ pregnant? Stage
_______ PMS
_______ other

OTHER
_______ cancer/tumors
_______ diabetes
_______ eating disorders
_______ loss of balance/dizziness
_______ depression
_______ drug/alcohol addiction
_______ nicotine/caffeine addiction

Are you currently taking any medications?____________________ If so, please describe: ____________________________________
Sleep: Average hours per night? ____________________

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE: ____ DATE: ______________________________

Melissa Chambers, LMT MA#0027645 MM#12964
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