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907 S. Lakewood Ave.
Baltimore, MD 21224
443.869.6584

Client Information

This confidential record will be kept in this office and will not be released to any person without your authorization.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

DOB _____ Phone ( ) _____

Email _____ Occupation _____

Emergency Contact Person: _____ Phone ( ) _____

I. Reason for seeking Massage Therapy

[ ] Overall health maintenance and relaxation [ ] I have a specific concern

Have you ever received a professional massage? [ ] Yes [ ] No

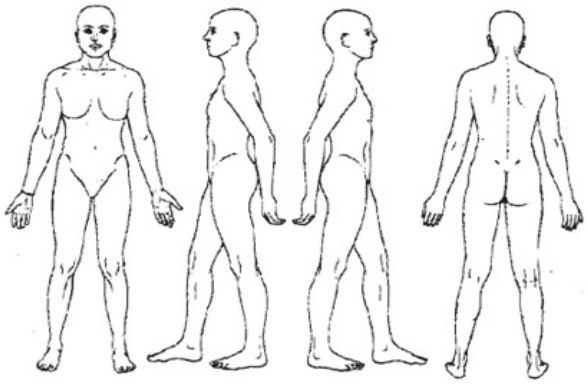
In order to better address your goals, please complete the following:

II. Specific Concern:

1. _____
Symptom Date of Onset

2. _____
Symptom Date of Onset

Mark any areas of pain or discomfort on the illustrations below with an "X":



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III. Medical History
Please check all that apply

__ Contagious Skin Condition
__ Sensitive Skin
__ Circulatory Disorders
__ High Blood Pressure
__ Recent injury or accident
__ Varicose Veins

* Any Joint Replacements? No Yes If yes, which joint(s)?_____

* Any Disc Bulge or Herniations? If so, where? _____

Women: Are you pregnant or trying to become pregnant? [ ] Yes [ ] No If you are pregnant, how many weeks? _____

IV. Surgical History: list any surgeries and the date of surgery.

_____ Date _____

_____ Date _____

_____ Date _____

V. Medications
Please list medications you are currently taking: _____

_____

Please provide any other information that you think is relevant for me to know in order to treat you safely and effectively:
_____

_____

Are you under the care of an MD, DO, Acupuncturist, or other primary health care provider? [ ] Yes [ ]No
if yes, please complete:

_____
Name of Provider

I have read and understood all of the questions on this form. My signature below confirms that I have answered all of the questions truthfully, and that I will inform this office of any changes in my health care status.

_____ _____
Client Signature Date