**Massage & Movement Synergy**

**(256) 653-8280** **www.massageandmovementsynergy.com** **njacobsel@yahoo.com**

# CLIENT HISTORY FORM

In order to maximize the effectiveness and safety of the massage session, please take the time to carefully fill out this questionnaire. This information will be treated confidentially.

Name: _____ Date of visit: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Contact Number: _____

Email address: _____ Occupation: _____

Emergency Contact: Name_____ Phone #: _____

Age/DOB: _____ How did you find out about us? _____

What is your goal/concern for today's session? _____

What type of pressure do you prefer? Light/Relaxation Firm Deep

The therapist may use her hands, elbows, forearms, knees and/or feet during the massage to deliver the most effective treatment. Do you have a problem with this? If yes, please explain _____

_____

Have you had a professional massage before? _____ Do you have any difficulty lying on your front or back? _____

If you are currently taking any medication please list the medication and its purpose (use reverse side):

| | | |
|---|---|---|
| Do you wear contact lenses or dentures? | Yes | No |
| Are you pregnant? | Yes | No |
| Do you have varicose veins? | Yes | No |
| Do you have high blood pressure? | Yes | No |
| Do you have or have you ever had a heart problem? | Yes | No |
| Have you ever had osteoporosis? | Yes | No |
| Have you ever had surgery or broken a bone? | Yes | No |
| Do you have rheumatoid arthritis? | Yes | No |
| Do you have any allergies? | Yes | No |

**Please explain yes to any answers (use reverse side).**

I _____, understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor does the therapist perform any spinal manipulations.

It has been made clear to me that massage therapy is not a substitute for medical examination or diagnosis and it is recommended that I see a physician for any physical ailment I might have. Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____ Date _____