soma
massage therapy

Client Information:

Name:_____

Address:_____

Home Phone:_____

Cell Phone:_____

Email:_____

Occupation:_____

Date of Birth:_____

In case of emergency, who should I contact?

Name:_____

Phone:_____

It is one of my highest priorities to keep your contact information and medical history absolutely private and confidential. I will not share any of this information, or any of the work that we do during your massage, with anyone, without either a subpoena or without your written consent.

Therefore, it is important that you are as detailed and thorough as possible with this form so that I can best treat you, knowing what sorts of contraindications I need to make in order to keep both of us safe and comfortable.

You may use the back of this form for additional information that you wish to provide.

Please sign and date this form, stating that the information you have provided is correct to the best of your knowledge.

Signature: _____

Date: _____

Health History:

Please list any medications you are currently taking:

1.
2.
3.
4.
5.

Please circle any conditions you currently have, or have had in the past:

Arthritis
Bruise easily
Bursitis Cancer
Carpal Tunnel
Chronic Fatigue Syndrome
Cold hands or feet Diabetes
Disk/Vertebrae problems
Fibromyalgia
Fungus
Grinding teeth
Headaches
High blood pressure
HIV
Leg/foot cramps
Loss of grip
Loss of movement (where? _____)
Migraines
Numbness/Tingling (where? _____)
Sciatica
Skin condition
Stiff neck
Stroke
Surgery (where? _____)
Swollen ankles
Thoracic Outlet Syndrome
Ticklish feet
TMJ
Pain with coughing/sneezing (where? __)
Pain with lifting/bending (where? _____)
Pain with movement (where? _____)
Pregnant (due date: _____)
Whiplash