

MESSAGE CLIENT INFORMATION AND HEALTH HISTORY

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone(home): _____ (cell) _____ Date of Birth: _____

Employer: _____ Occupation: _____

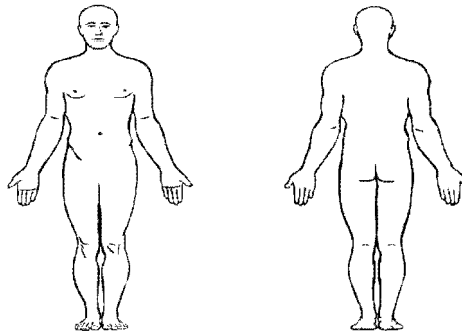
Emergency contact: _____ Phone: _____ Relationship: _____

Referred by: _____ e-mail: _____

Is this your first professional massage? _____ If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage? _____

Are you aware of any tension holding spots in your body? _____ If yes, show location on the diagram below:



Do you have any chronic, ongoing pain that you deal with on a regular basis? _____

Please explain: _____

Describe what activities cause this pain and/or make it worse: _____

Are you receiving any other type of medical treatment? _____ Please explain: _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

Are you currently under the care of a physician? _____ Whom? _____

Please list reason(s): _____

Are there any other health concerns you wish to discuss today? If yes, please describe: _____

Are you currently experiencing any of the following conditions?

Flu or Cold Inflammation Fever Infection Contagious Disease

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years:

MUSCULOSKELETAL

- Fibromyalgia
- Spasms/Cramps
- Sprains/Strains
- Osteoporosis
- Postural Deviations
- Gout
- Osteoarthritis/Rheumatoid Arthritis
- TMJ
- Cysts
- Bursitis
- Plantar Fasciitis
- Tendonitis
- Torticollis
- Whiplash Syndrome
- Carpal Tunnel Syndrome
- Sciatica
- Thoracic Outlet Syndrome
- Headache
- Leg Pain
- Arm Pain/Shoulder Pain
- Low Back Pain
- Mid Back Pain
- Hip Pain
- Other _____

RESPIRATORY

- Pneumonia
- Sinusitis
- Asthma
- Trouble Breathing
- Dizziness
- Other _____

CIRCULATORY

- Anemia
- Hemophilia
- Hypertension
- Low Blood Pressure
- Raynaud's Disease
- Varicose Veins
- Heart Condition
- Blood Clots/Phlebitis
- Diabetes
- Other _____

DIGESTIVE

- Ulcers
- Irritable Bowel Syndrome
- Colitis
- Gallstones
- Hepatitis
- Crohn's Disease
- Diarrhea
- Gas/Bloating
- Indigestion
- Other _____

SKIN

- Fungal Infections
- Acne
- Impetigo
- Dermatitis/Eczema
- Psoriasis
- Rashes
- Warts/Moles
- Other _____

NERVOUS SYSTEM

- ALS
- Multiple Sclerosis
- Parkinson's Disease
- Bell's Palsy
- Neuritis
- Spinal Cord Injury
- Stroke
- Trigeminal Neuralgia
- Seizure Disorders
- Numbness/Tingling/Twitching
- Other _____

OTHER

- Insomnia
- Anxiety/Panic Attacks
- PMS
- Grief Process
- Cancer
- Substance Abuse
- Pregnancy
- Chronic Fatigue
- HIV/AIDS
- Lupus
- Kidney Disease
- Bladder Infection
- Postoperative Situation
- Edema
- Other _____

The above information is accurate and true to the best of my knowledge. I understand that Karen Stresau does not diagnose disease or prescribe medications. I further understand that the services rendered are not a substitute for medical attention or examination.

Signature: _____ Date: _____