Massage Therapy at 24 Church Street
24 Church Street, Watertown, MA 02472

Client Information & Health History

Name_____ Today's Date_____
Address_____
City_____ State ____ Zip _____
Mobile Phone _____ Home Phone _____
Date of Birth _____ Email Address _____
Would you like text reminders the day before appointment? Yes No
Referred by _____ Have you had a massage before? Yes No
About how many months/years was your last massage? _____
Anything you liked or disliked about your previous massage?
_____
Occupation _____ How many hours do you sit at your job?___
On a scale of 1 to 10 (1 least), what is the amount of stress in your life? ___
What type of exercise do you do? _____
How often? _____ of days per week. Or ___ times a month.

Are you under a doctor or other health practitioner's care? Yes No
If yes, please give a brief description: _____
_____

Please place a check on any of the following that apply to you:

Heart Disease __	Bursitis ___list location(s) below	Headaches __
Stroke __	Location:	Epilepsy __
High Blood Pressure __	Painful Joints ___ list below	Diabetes __ Type I / II
Low Blood Pressure __	Location:	Fibromyalgia __
Poor Circulation __	Edema ___ list location(s) below	Insomnia __
Phlebitis __	Location:	Painful Menstruation __
Varicose Veins __	Swelling___ list location(s) below	Pregnant __
Heart Attack __	Location:	Skin Rash __
Pace Maker __	Numbness ___ list below	Skin Infection __
Bruise Easily __	Location:	Drug Use __
Asthma __	Cancer ___ list below	Alcohol Use__
Sinus Infection __	Location:	Other _____
Smoking __	Lymph Node Removal _	

Allergies (Please list all) _____
_____

List any surgeries, hospitalizations, accidents or injuries you have had, and any open or healing wounds (please include year on incident):

_____

_____

_____

_____

Please list any medications you are currently taking: (specifically anti-inflammatory, pain killers, muscle relaxers, insulin and blood thinners)

_____

_____

Describe the nature of the pain – is it local, does it radiate outward, is there restriction of movement?

_____

_____

When did pain start? _____ What helps relieve pain? _____

_____

What are your expectations for your session?

_____

_____

Other health conditions or comments you would like massage therapist to know: _____

_____

By signing this document, I, _____, understand that this is a confidential medical history and that all medical records and conversations will remain private. Advice from the massage therapist is non-medical and does not replace seeing a doctor. I understand that my massage therapist will only work within her scope of practice, that I have the right to ask my therapist not to massage any part of my body I am not comfortable having massaged. I also will let massage therapist know during the treatment if I do not like what the therapist is doing or how it feels. This massage is for the purposes of relaxation and the relief of stress and muscular tension.

I give my consent for my massage therapist to treat me.
Signature_____Date_____

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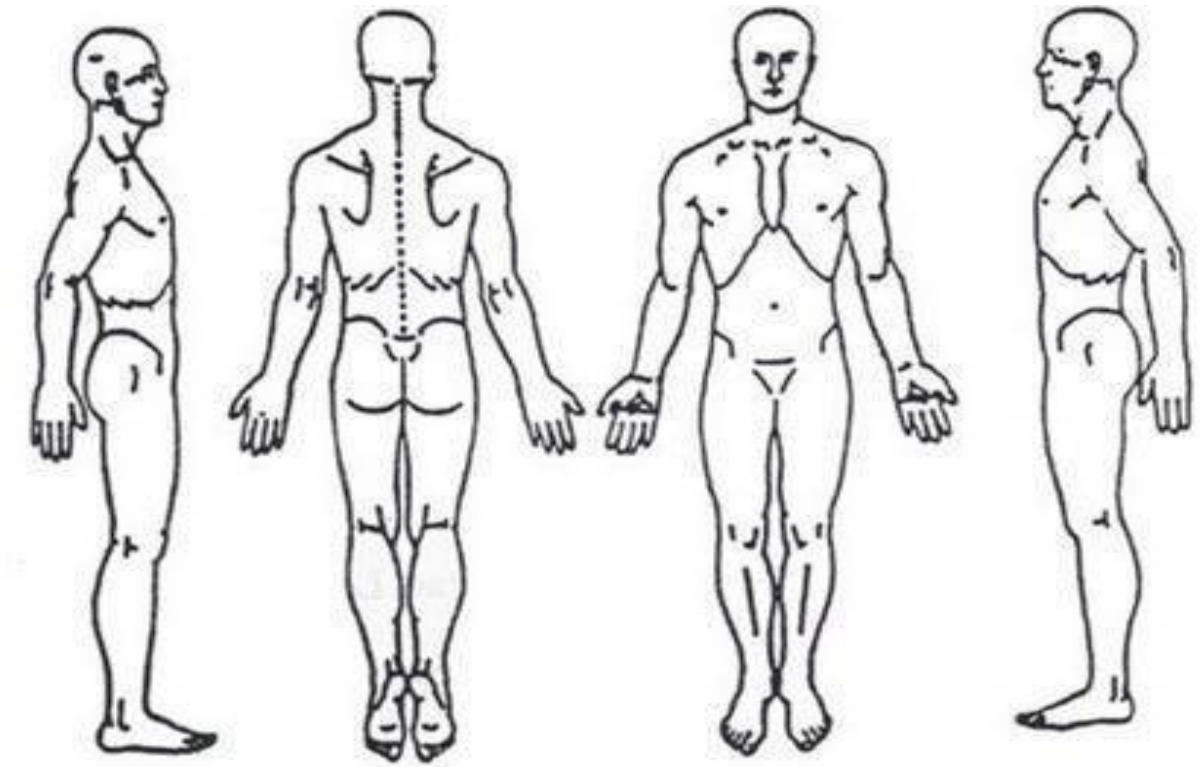

Right Side Back Front Left Side

Please circle areas of the body you would like extra focus, place an X on areas you would like to be avoided and a line where you have any scar you feel comfortable noting.

Preferred Pressure (circle one): Light Moderate Firm Deep

Signature: _____Date _____