Print Form

Life Source Confidential Client History

Name: _____Today's Date _____

Address_____City_____Zip_____

Home _____ Work _____ Cell _____ Email_____

Emergency Contact Relationship & Number: _____

Family Doctor Name _____Number _____

May I contact if necessary? Yes ☐ No ☐ Comments_____

Date of Birth _____ Marital Status M ☐ S ☐ W ☐ Referred By: _____

Occupation (be specific): _____

How Many Hours a day do you use the Computer _____

What are your main Stressors? _____

If any part of your daily regimen changes such as medications, or therapies, Please inform your therapist at your next visit.

Please indicate all conditions that apply.

Joint/Muscle Pain
- ☐Arms R ☐ / L ☐
- ☐Upper Back R ☐ / L ☐
- ☐Mid Back R ☐ / L ☐
- ☐Low Back R ☐ / L ☐
- ☐Degenerative Discs
- ☐Feet R ☐ / L ☐
- ☐Hands R ☐ / L ☐
- ☐Hips R ☐ / L ☐
- ☐Jaw R ☐ / L ☐ (TMJD)
- ☐Braces Y ☐ / N ☐
- ☐Knees R ☐ / L ☐
- ☐Legs R ☐ / L ☐
- ☐Neck R ☐ / L ☐
- ☐Osteo Arthritis
- ☐Rheumatoid Arthritis
- ☐Sciatica R ☐ / L ☐
- ☐Shoulders R ☐ / L ☐
- ☐Other

Skin
- ☐ Rashes
- ☐Bruise Easily
- ☐Open cuts
- ☐Other

General Symptoms
- ☐Headaches (Tension)
- ☐Migraines
- ☐Loss of Sleep _____
- ☐Fatigue (Chronic)
- ☐Tingling _____
- ☐Numbness _____
- ☐Other

Cardiovascular
- ☐High Blood Pressure
- ☐Low Blood Pressure
- ☐Coronary Heart Disease
- ☐Phlebitis
- ☐Heart attack _____
- ☐Stoke /CVA
- ☐Varicose Veins
- ☐Blood Clots/DVT
- ☐Other

Eye & Ear
- ☐Contacts
- ☐Hearing Loss R ☐ / L ☐
- ☐Other

Digestive
- ☐ IBS
- ☐Colitis
- ☐Ulcers
- ☐Kidney Disease
- ☐Other

Respiratory
- ☐Bronchitis
- ☐Asthma
- ☐Difficulty Breathing
- ☐Other

Chronic Disease
- ☐Cancer /Tumor
- ☐Chemo /Radiation
- ☐Lymph nodes biopsied/dissected
- ☐Lymph nodes removed _____
- ☐Diabetes
- ☐Fibromyalgia
- ☐Lupus
- ☐Seizures
- ☐Vertigo
- ☐Shingles

Reproductive
- ☐Pregnant - Due Date _____

Do you have any Contagious or Infectious Diseases I need to know about? Y ☐ / N ☐
HIV ☐ Athlete's Foot R ☐ / L ☐ Other _____

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Lifestyle Questions

Energy Level: High ☐ Average ☐ Low ☐ Favorite Sleeping Position: Stomach ☐ Back ☐ L ☐ / R ☐
Regular Exercise **Yes** ☐ **No** ☐ Type _____ Frequency_____
Do you take Nutritionals' Yes ☐ No ☐ Type _____

Previous massage Experience: _____
Massage for what issues? _____
List Surgeries? _____
What did you like? _____
What didn't you like? _____
Massage of particular areas to avoid: _____
Areas to concentrate on: _____

Medication that you are taking and why:
Do you have any allergies to anything?

_____
_____
_____

About You

Daily water intake in oz. _____
Blood Type A ☐ / B ☐ / O ☐ / AB ☐
Height _____
Weight _____

Please read thoroughly, and sign.

The information I have provided is ***true and complete to the best of my knowledge.***
As massage therapists we do not diagnose or treat disease and are not a substitute for physicians care!
All of my information is ***confidential and will not be released without my written consent.***
I ***consent to therapeutic*** massage treatments by a Life Source Massage Therapist.
I also understand that **payment is due at the end of session** unless other arrangements are made.
24 hours notice is required to reschedule all future appointments, or full charge can apply.
If you arrive ***late*** to an appointment your ***time may be shortened*** due to other scheduled appointments.
I also understand that the massage ***can be ended*** at any time by the ***therapist or the client for any reason.***
Sexual Innuendo's will not be tolerated in this establishment, and will be grounds for ending the session and any further sessions in this establishment…
Do you have any questions before we begin the massage session?

_____ _____
Signature Today's Date

Print Form

Therapist will complete.

Treating Therapist_____

Duration of Massage _____ Cost $ _____

Techniques Used_____

Comments_____

Self Care Recommendations_____