

Massage & Wellness Therapy

Sharon Kennington

Client History

Today's Date: _____

Please circle areas of concern

Name _____ Date of birth _____

Address _____ Phone (day) _____

City/Zip _____ Phone (eve) _____

Occupation(s) _____

Email address: _____

Who referred you? _____

Interest(s) _____

Is there any area where you hold a lot of tension? _____

Previous experience with professional massage? *None* *Occasional* *Regular*

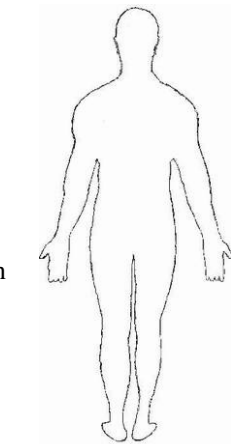
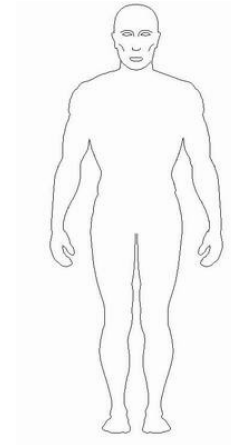
Do you prefer *Light* *Moderate* *Deep* massage pressure?

Are you *cold natured* *moderate* *hot natured?*

Are you *right-handed* *left-handed?*

Daily exercise? *None* *Occasionally* *Regularly*

Posture assumed most of day *Sitting,* *Standing,* *Varied?*



Medical History:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abscess or open sore | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> PMS/painful menstruation |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Cancer/Malignancy | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Skin sensitivity |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spinal Curvature Problem |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Phlebitis | |

Surgery/fractures (explain & Date) _____

Medications _____

History (Car Accidents & year, Medical Condition, etc) _____

Are there specific aspects of your life that are particularly stressful? (job, posture, habits, diet, family, etc)? (explain)

Name of Physician _____ Phone _____

Signature _____ Date _____