INSPIRE WELLNESS
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Client: ______________________________ Date: ______________
Address: ____
City: ____________________ State: __________ Zip: ______________
Occupation ________________ Date of Birth ________________________
Phone (day) ________________ Email ____________________________
Emergency Contact ______________________ Phone ________________

GENERAL HEALTH INFORMATION
Have you ever had a massage before? ______ When? ________________________
What are your current goals for massage? ______________________________
List your typical daily activities-work, exercise, home. ______________________
____

Are you currently experiencing the following? If yes, please explain and list any medication you have taken to address the issue in the past 24 hours.

pain, tenderness ☐ No ☐ Yes: ______________________________________
numbness, tingling ☐ No ☐ Yes: ______________________________________
allergies ☐ No ☐ Yes: ______________________________________
stiffness ☐ No ☐ Yes: ______________________________________
swelling ☐ No ☐ Yes: ______________________________________

Please check if you have had or are currently experiencing any of the following:

___ fever
___ heart trouble
___ inflammation
___ kidney problems
___ stress
___ migriane HA
___ skin problems
___ allergies
___ bursititis
___ muscle tension
___ back pain
___ anxiety

___ high blood pressure
___ swollen feet or legs
___ tumors
___ any contagious disease
___ insomnia
___ diabetes
___ digestive problems
___ sciatica
___ sprain
___ neck pain
___ muscle spasm
___ depression

___ low blood pressure
___ varicose veins
___ cancer
___ poor circulation
___ headaches (non-migraine)
___ seizures
___ constipation
___ arthritis
___ strains
___ joint problems
___ herpes
___ HIV +

Comments on any of the checked items above:

What substances are you currently taking? (prescribed medications, over the counter medications, herbs, supplements, alchohol, recreational drugs) ______________________________________

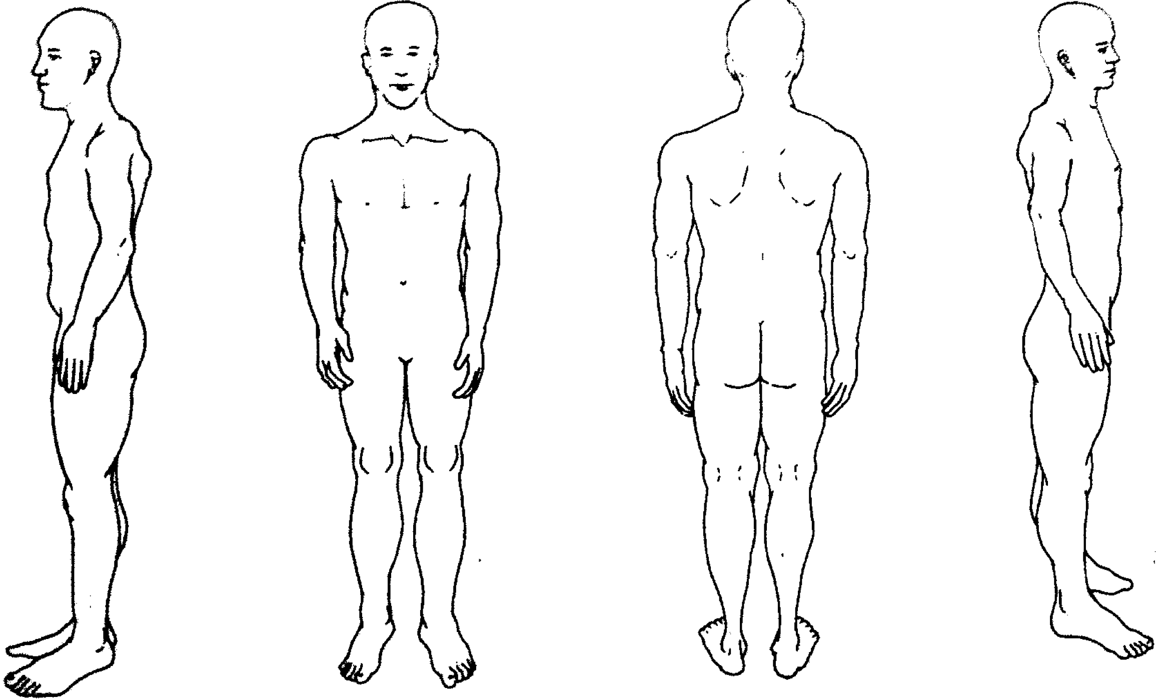
____

Please list all major illnessnes (include dates), injuries, surgeries and health concerns you have now or have occured in the last 3 years. (examples: arthritis, cancer, whiplash, pregnancy)__________

____

Please circle and write in a letter indicating any current problem areas on the figures below:

P = Pain **S = Stiffness** **N = Numbness**



How do you currently deal with stress? ____

____

Any additional comments? ____

____

Client Acknowedgement and Agreement:

I understand that massage therapists do not provide diagnosis, or prescribe any treatment or medications and I acknowledge that massage therapy is not a substitute for medical care. I have disclosed all of my known medical conditions, medications, and/or injuries. I affirm that this information is true, accurate, and current. I agree to inform the massage therapist of any changes in my health status if/when they occur.

I understand that massage therapy may provide relaxation, relief from muscle tension, and an increase in circulation and range of motion. I understand that some treatments, in regards to massage therapy, may result in muscle tenderness, mild flu-like symptoms, or unusual lethargy within 24 hours after treatments and that drinking water may help to prevent this. During the session(s), my comfort level will always come first.

I understand that I am financially responsible for payment of this account and/or charges that are not covered by insurance. I agree to give a minimum of 24 hours cancellation notice and understand that I may be charged the full session fee in the event of a late cancellation or “no show”.

I give my consent to receive treatment and understand that I may change or end the massage session at any time.

Client Signature: ____ Date:_______________

Parent/Guardian Signature:___________________________________ Date:_______________

(if client is under the age of 18)