NEW CLIENT HEALTH INFORMATION

MARY E LMT LLC

Patient Information

Name (Last First M.I.): ____ Today's Date______________

Address (Number Street City State Zip):____

Phone numbers (Home Alternate): _____________________________________. Email: _____________________________

Date of Birth: _________________________. Occupation: ____

Emergency Contact: ____Emergency Phone: ___________________________

Referred by: _______________________________________

Symptoms

Please describe your chief health concern(s): ____
____

Health History

Have you had any recent illnesses, accidents or surgeries? ( )Y ( )N If yes, please explain _______________________________
____

List All Current Medications, Vitamins, and Supplements -- Include Prescription, Over the Counter & Herbal _______________
____

Please mark the type of pain or discomfort you experience: Shooting, Dull, Stiff, Numb, Throbbing, Tingling, Sharp, Achy

Please mark which, if any, of the below activities are painful.
Sitting, Bending, Standing, Lying Down, Lifting, Walking, Twisting, Running

Do you have problems with any of the following? Please mark "C" for current conditions, and "P" for Past:

( ) Diabetes ( ) Skin Problems ( ) Circulation Problems ( ) Cancer ( ) Chronic Illness ( ) High Blood Pressure ( ) Infection ( ) Headaches
( ) Allergies ( ) Pregnancy ( ) Heart Disease ( ) Arthritis ( ) Seizures ( ) PTSD ( ) Autoimmune Disorders
( ) Other ____

Have you had any recent (in the last 10 days) new symptoms including but not limited to: fatigue, fever, cough, congestion, new skin conditions including bumps, rashes or unexplained redness? ☐ Yes ☐ No

I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment nor perfom spinal manipulations. I will inform the therapist of my current condition at the time of each visit.

Signature _________________________________ Date: ______________________________

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**Please answer the questions below.

How did you learn about us? ____________________

Have you received massage therapy or bodywork before? ☐ Yes ☐ No

Are you on any medication? ☐ Yes ☐ No If yes, which ones ____________________

Do you exercise? ☐ Yes ☐ No If yes, how many times per week ? ____ How many hours?

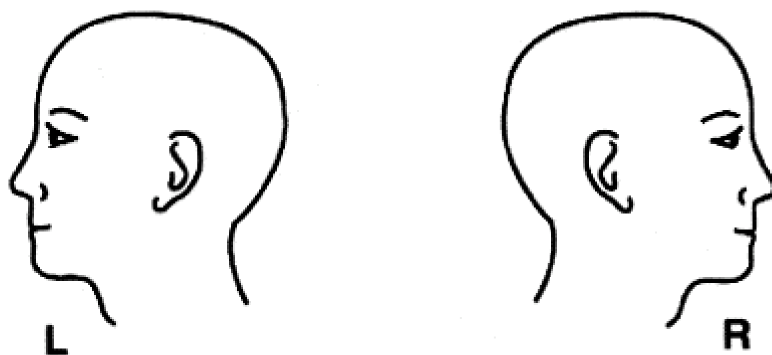
May we include you in our email list for practice updates and free client resources? ☐ Yes ☐ No

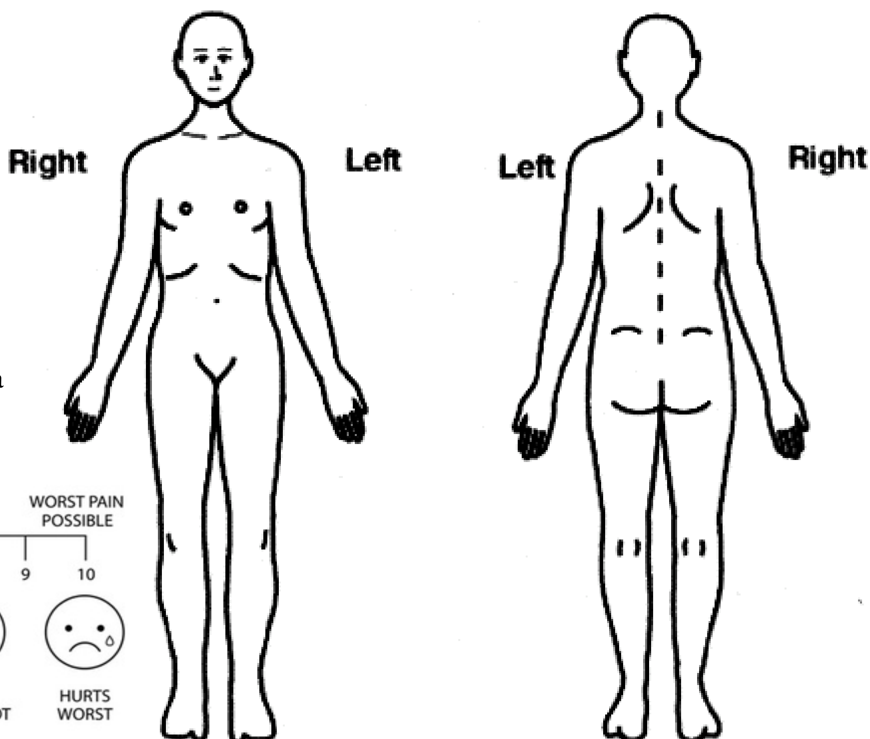
**Please mark the following areas you consent to receive touch:

☐ Head	☐ Back	☐ Feet
☐ Face	☐ Hands	☐ Abdomen
☐ Neck	☐ Legs	☐ Buttocks/Hips

**On the diagram please mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations:

Key:
A - Aching
P - Pins and Needles
B - Burning
S - Stabbing
N - Numbness
O - Other





**Rate the severity of your pain by marking a number on the scale below: