sarasota school of massagetherapy

CLIENT HEALTH INFORMATION

Date: _____

Name:_____ ❑ Female ❑ Male

Address: _____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Alternate Phone:_____

Email:_____ DOB: _____

Occupation:_____ Activities:_____

Emergency Contact Name & Number:_____

MEDICAL BACKGROUND

Are you presently being treated by a physician or other medical personnel? ❑ Yes ❑ No

If yes, please explain:_____

_____

List any current medications - including aspirin, ibuprofen, herbs, supplements, etc.

_____

_____

List Allergies:_____

Check all conditions you are being treated for, or have been treated for in the past:

❑ Arthritis ❑ Blood Clots ❑ Cancer ❑ Diabetes ❑ Heart Condition ❑ Infection

❑ Inflammation ❑ Muscle/Joint Pains ❑ Rashes ❑ Kidney Disorder ❑ Pregnancy

❑ Ruptured/Bulging Disk ❑ Seizure Disorders ❑ Stroke ❑ Tension/ Stress

❑ Varicose Veins/ Thrombophlebitis ❑ Vision/Hearing Conditions

❑ Recent Surgeries/Other:_____

If yes to any of the above, please explain:_____

_____

_____

This information is useful for the student to be more effective in treating you, and to insure that massage is safe for you. It is not within the scope of a massage therapist (or a student) to diagnose—this information is for assessment purposes only.

I understand that this massage is not a replacement for medical care and that no diagnosis will be made. I agree to pay an operations fee in advance and to complete a short evaluation form after the treatment has concluded.

Client Signature: _____ Date: _____

FOR SSMT USE ONLY: Dr.'s Note Requested ❑ Yes ❑ No – If yes, Dr.'s Note Received ❑ Yes ❑ No