Sublime
MASSAGE THERAPY

Client Medical History

Name ____________________ Phone ____________________

Address ____________________ Zip ____________________

Have you had previous massage therapy/body work?

If yes, when was your last treatment? ____________________

Are you involved in a regular excersize program?

If yes, what type? ____________________ How often? ____________________

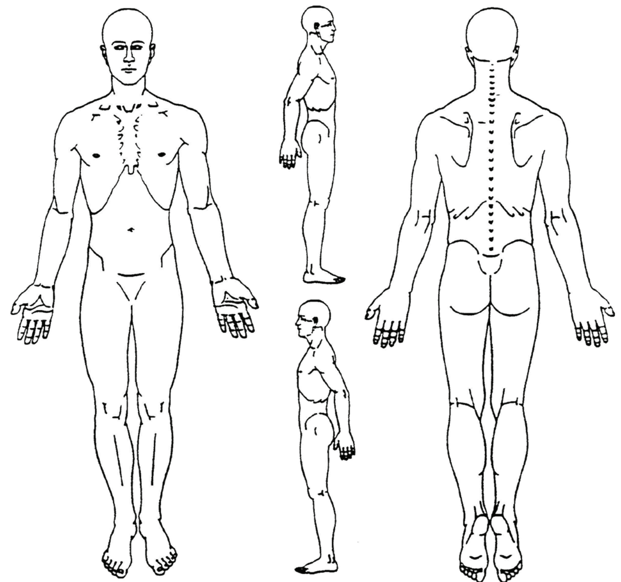
Please list any medications you take regularly. ____________________

What is your major complaint? ____________________

Do you have any of the following?

Artreriosclerosis
Arthritis
Asthema
Bruising Tendency
Cancer
Contact Lenses
Depression
Diabetes
Dizziness
Epilepsy
Headache
Heart Disease
Hernia
Hemophilia
High Blood Pressure
Low Blood Pressure
Musculoskeletal Problems
Phelbitis
Pins/Pacemaker
Pregnancy
Skin Trouble
Stomach Ulcers
Varicose Veins

Mark areas of discomfort:



I understand that the massage therapy that I am given is for the purpose of stress reduction, releif from muscular tension or spasm, and/or improving circulation. I understand that a massage therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorders; nor performs any spinal minipulations. I am responsible for consulting a qualified physician for any physical ailment I may have.

Signature ____________________ Date ____________________