Louise Rosenberg
Graceful Strength Massage Therapy

Client History

Name ______________________________________ Date _________________

Date of Birth____________________ Occupation ________________________

Phone #1 _______________________ Phone # 2 _________________________

Email ____

Address ____

____

I was referred by____

Is there any pain problem or injury that you currently have?

____

____

Have you had any significant medical conditions in the past?

____

____

Are you seeing any other health care practitioners?

____

____

Are you currently taking any medications? If so, please list.

____

____

Do you exercise or stretch: Regularly___ Occasionally___ Rarely____

What kind of exercise? ____

Where in your body do you carry stress and tension?

____

____

What things do you enjoy doing?

____

____

Have you had massage or bodywork before? Yes____ No____

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If yes, what things did you find helpful?

____

____

Were there things that were not helpful, or things you did not like?

____

____

Is there any part of your body where you prefer not to receive work?

Yes____ No____ ____

Do you have particular practices or strategies that you use to cope with any symptoms you experience? If so, please note.

____

____

Do you have any particular ways of dealing with stress? Please note.

____

____

What things do you specifically want to address with massage?

Please check all that apply:

Stress Relief ___ Pain Relief ___ Muscle Tension __ Headache ___

Improved Sleep __ Reduced Depression ___ Rejuvenation ____

Other____

Is there anything else you would like me to know before we begin?

____

____

As a licensed massage therapist I am not trained to diagnose conditions or treat them medically. It is the client's responsibility to seek medical care appropriately and to keep the therapist updated on your health.

____

Signature Date