Bohemian Bodywork

Alicia Hamilton, LMT

Client Information Form

Name: _____ Date: _____
Date of Birth: _____ Referred By: _____
Address: _____
City: _____ State: _____ ZIP: _____
Email: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Physician: _____ Phone: _____
Covered Hospital: _____ Occupation: _____

MASSAGE INFOMRATION

Have you ever received professional massage/bodywork before? Yes No
How Recently? _____
What types of massage/bodywork do you prefer? _____
What type of pressure do you prefer? Light Medium Firm Deep
What are your goals/expected outcomes for receiving massage/bodywork? _____

_____

_____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.): _____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)?
Yes No Explain: _____

_____

List any medications you are currently taking: _____

_____

Are you wearing contacts? Yes No
Are you wearing dentures? Yes No
Are you wearing a hairpiece? Yes No
Are you pregnant? Yes No

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment? _____

_____

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask)
Please answer honestly, as massage may not be indicated for the below conditions:

blood clots infections congestive heart failure contagious diseases pitted edema

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain _____
Current Past Muscle or joint stiffness _____
Current Past Numbness or tingling _____
Current Past Swelling _____

Current Past Bruise easily _____
Current Past Sensitive to touch/pressure _____
Current Past High/Low blood pressure _____
Current Past Stroke, heart attack _____
Current Past Varicose veins _____
Current Past Shortness of breath, asthma _____
Current Past Cancer _____
Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____
Current Past Epilepsy, seizures _____
Current Past Headaches, Migraines _____
Current Past Dizziness, ringing in the ears _____
Current Past Digestive conditions (e.g. Crohn's, IBS) _____
Current Past Gas, bloating, constipation _____
Current Past Kidney disease, infection _____
Current Past Arthritis (rheumatoid, osteoarthritis) _____
Current Past Osteoporosis, degenerative spine/disk _____
Current Past Scoliosis _____
Current Past Broken bones _____
Current Past Allergies _____
Current Past Diabetes _____
Current Past Endocrine/thyroid conditions _____
Current Past Depression, anxiety _____
Current Past Memory Loss, confusion, easily overwhelmed _____

Comments: _____

***Please give 24 hours notice if you need to cancel. Late cancellations and no shows will be charged the full fee for the missed appointment. Thank you for understanding. X_____initials.

I understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension, spasm, or for increased circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my health.

Signature: _____ Date: _____