BODYWISE MUSCULAR THERAPY

4 Courthouse Lane Suite #16

Chelmsford, MA 01824

978-674-8838

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

NAME_____DATE_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE_____EMAIL_____

EMERGENCY CONTACT_____PHONE_____

HOW DID YOU HEAR ABOUT BODYWISE_____

_____

Is this your first professional massage?_____How frequently do you get massage?____

What is your major complaint or condition you are seeking help with today?

_____

When did this begin?_____What have you done to get relief?_____

Do you have chronic ongoing pain you deal with on a regular basis? _____

_____

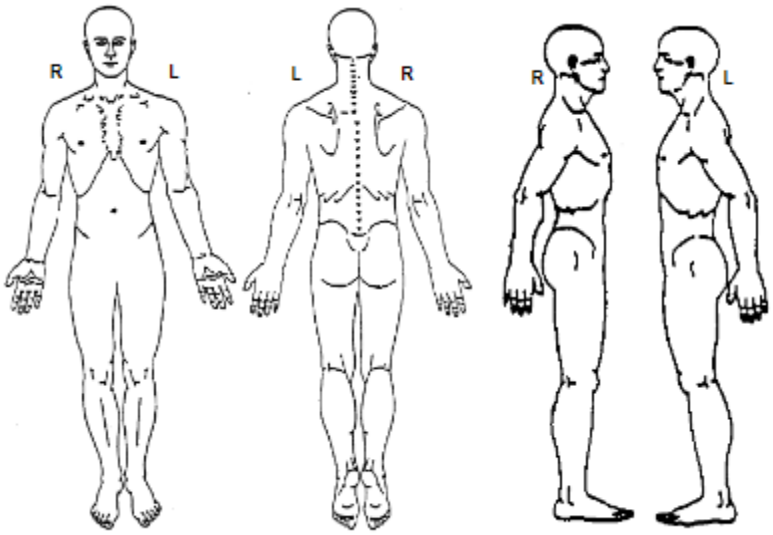
Describe what activities cause this pain, or make it worse. _____

_____

Are you under medical/therapeutic treatment? _____

Please list all medications and nutritional supplements you are taking_____

_ _____



Please indicate where you feel pain on the drawing above

Please list any surgeries you have had. _____

_____

Please list any medical conditions or diagnosis. _____

_____

Please list any additional comments regarding your health and well-being._____

_____

_____

The information I have provided is accurate and complete to my knowledge. I understand massage is not a substitute for medical attention. II take all responsibility for alerting my therapist to any changes in my health status as well as all responses perceived to be a result of massage therapy. This facility reserves the right to refuse services at their discretion based on client condition, attitude, or action.

Signature_____Date_____