



Janet Herman, LMT

Therapeutic Massage & Bodywork since 1991

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404-422-4899
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Confidential Health Information

Today's Date: _____

Client Contact Information

Name: _____ Date of Birth: _____
Address: _____ State: _____ Zip: _____
Primary Phone: _____ (Cell - Hm - Wk) Alternate Phone: _____ (Cell - Hm -Wk)
Email: _____ Referred by: _____
Emergency contact: _____ Phone: _____
Is this massage/bodywork medically necessary (is it for a medical condition, injury, or surgery)? Yes No
Physician/Health-care Provider name: _____ Phone: _____
Do you have a physician referral/prescription? Yes No Occupation: _____

Massage Information

Have you ever received professional massage/bodywork before? Yes No Date of Last Massage: _____
Frequency of Massage Therapy: _____ Type of pressure do you prefer: Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork?

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

How are you feeling today? _____
Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work)? Yes No
Explain _____
Type and amount of exercise: _____

Health History

List all medications you currently take (Prescription, OTC, vitamins, supplements, and hormones):

List all Injuries with dates starting with the most recent:

List all Surgeries with dates starting with the most recent:



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Circle any of the following health conditions that you currently have:

Blood Clot ~ Infectious or Contagious Disease ~ Fever ~ Congestive Heart Failure ~ Pitting Edema

Please indicate conditions that apply:

- | | | | | | |
|---------|------|--|---------|------|--|
| Current | Past | Under Frequent Stress | Current | Past | Headaches or Migraines |
| Current | Past | Anxiety/Depression | Current | Past | Scoliosis |
| Current | Past | Insomnia, Sleeplessness | Current | Past | Cancer/Tumors |
| Current | Past | Muscle Pain, Cramping or Tension | Current | Past | Arthritis (Rheumatoid or Osteoarthritis) |
| Current | Past | Joint Pain/Inflammation/Stiffness | Current | Past | Stomach or Digestive Problems |
| Current | Past | Swelling/Edema | Current | Past | Kidney or Bladder Problems |
| Current | Past | Numbness or Tingling | Current | Past | Seizures/Epilepsy |
| Current | Past | Skin Problems or Lesions | Current | Past | Fibromyalgia or Chronic Fatigue |
| Current | Past | Bruise Easily | Current | Past | Menstrual Problems (Female) |
| Current | Past | Allergies or Sinus Problems | Current | Past | Prostate Problems (Male) |
| Current | Past | Brain or Nerve Disorders | Current | Past | HIV Infection/AIDS |
| Current | Past | Dizziness, Vertigo, Fainting | Current | Past | Pregnant or Attempting to Conceive |
| Current | Past | High Blood Pressure | Current | Past | Drug or Alcohol Addiction |
| Current | Past | Mental or Emotional Disorders | Current | Past | Nicotine or Caffeine Addiction |
| Current | Past | Diabetes | Current | Past | Wearing Contact Lenses |
| Current | Past | Varicose Veins | Current | Past | Sensitive to Touch/Pressure _____ |
| Current | Past | Heart or Circulation Problems | Current | Past | Arm or Leg Pain |
| Current | Past | Asthma, Shortness of Breath, Lung Disorder | Current | Past | Any other Condition(s) not Listed _____ |
| Current | Past | Thyroid or Endocrine Disorder | | | _____ |
| Current | Past | Osteoporosis or Degenerative Spine/Discs | | | _____ |

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____

LMT Treatment Notes: