MEMBER
Associated Bodywork & Massage Professionals

Janet Herman, LMT
Therapeutic Massage & Bodywork Since 1991
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Confidential Health Information

Today's Date: _____

Name: _____ Date of Birth _____

Address: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Join email list? (Circle One) Yes No

Referred by: _____ Occupation: _____

Emergency contact: _____ Phone: _____

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.):

_____

_____

Do 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	Anxiety/Depression
Current	Past	Insomnia, Sleeplessness
Current	Past	Muscle Pain, Cramping or Tension
Current	Past	Joint Pain/Inflammation/Stiffness
Current	Past	Swelling/Edema
Current	Past	Numbness or Tingling
Current	Past	Skin Problems or Lesions
Current	Past	Bruise Easily
Current	Past	Allergies or Sinus Problems
Current	Past	Brain or Nerve Disorders
Current	Past	Dizziness, Vertigo, Fainting
Current	Past	High Blood Pressure
Current	Past	Mental or Emotional Disorders
Current	Past	Diabetes
Current	Past	Varicose Veins
Current	Past	Heart or Circulation Problems
Current	Past	Asthma, Shortness of Breath, Lung Disorder
Current	Past	Thyroid or Endocrine Disorder
Current	Past	Osteoporosis or Degenerative Spine/Discs

Current	Past	Headaches or Migraines
Current	Past	Scoliosis
Current	Past	Cancer/Tumors
Current	Past	Arthritis (Rheumatoid or Osteoarthritis)
Current	Past	Stomach or Digestive Problems
Current	Past	Kidney or Bladder Problems
Current	Past	Seizures/Epilepsy
Current	Past	Fibromyalgia or Chronic Fatigue
Current	Past	Menstrual Problems (Female)
Current	Past	Prostate Problems (Male)
Current	Past	HIV Infection/AIDS
Current	Past	Pregnant or Attempting to Conceive
Current	Past	Drug or Alcohol Addiction
Current	Past	Nicotine or Caffeine Addiction
Current	Past	Wearing Contact Lenses
Current	Past	Sensitive to Touch/Pressure_____
Current	Past	Arm or Leg Pain
Current	Past	Any other Condition(s) not Listed _____

_____

_____

Consent for Treatment

I 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. If I experience any pain or discomfort during this, or any future session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. 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: