Mary Axelrod, BCMT, LMT, CR
Board-Certified, Licensed Massage Therapist, Certified Reflexologist, Aromatherapist

Client Health History & Information

Personal: Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____
Street City State Zip

Phone: H _____ W _____ Cell _____ Email: _____

Occupation: _____ Employer: _____ How Long: _____

Hobbies: _____ Marital Status: (optional) _____

In case of emergency, notify: _____ Relationship to you: _____
Name Phone

What would you like to accomplish with Massage / Reflexology / Energy Work? _____

Medical History:

Are you pregnant: yes no If yes, you must bring a written ok for massage from your doctor or certified midwife.

Are you currently receiving any medical or therapeutic treatment: yes no

If so, for what condition(s): _____

Medications you are currently taking: _____

How many cups per day do you drink: Water _____ Coffee _____ Tea _____ Soda: _____

Major accidents, broken bones, injuries and surgeries (last 5 years): _____

_____

Please mark: (x) if you **currently** have

_____ Athletes Foot
_____ Arthritis – where? _____
_____ Asthma
_____ Blood Clot - where? _____
_____ Cancer _____
_____ Contagious or Infectious Disease
_____ Diabetes Insulin: Y N
_____ Had a Depo or Birth Control Shot
_____ Estrogen Patch
____ Frequent Headaches: How Often? _____
Migraine Cluster Tension PMS
_____ Fibromyalgia

_____ Heart Problems, when? _____
_____ ____ Heel Spur- which foot? Ingrown Toenail(s)
_____ Joint Dislocations where: _____
_____ Numbness where: _____
_____ Poor Circulation – where: _____
_____ Plantar Fasciitis
_____ Seizures or Epilepsy
_____ Tendonitis – where? _____
_____ High or Low Blood Pressure
_____ Varicose Veins – where _____
_____ Swelling - hands or feet
Other Problem(s), (specify)

Do You Have Chronic Pain: Yes No Where: _____

Caused by: _____

TURN OVER ⇨

Are you feeling well today? Yes No if no, reason? _____

How would you rate your current overall health 1-10 scale (1 = bad, 10 = excellent) _____

Activity

What do you do for exercise:_____How Often: _____

In Your Normal Daily Activity what % do you _____sit ____stand _____walk ____lift

Allergies

Any known allergies: _____ if yes, specify _____

Emotional/Stress:

Low Medium High

Rate your overall level of stress: 1 2 3 4 5 6 7 8 9 10

Where in your body do you carry tension & stress? _____

What causes your stress? _____

How do you relieve stress in your life? _____

Have you ever experienced: Professional Massage Reflexology

When:_____Comments (positive or negative) about your experience: _____

To the best of my knowledge all this information is accurate and true. I realize my therapist is not a medical doctor and cannot diagnose or prescribe. I understand that massage and/or reflexology therapy is not a substitute or replacement for standard medical care.

I understand that these massage and reflexology therapies are based on the highest standards of ethical and professional conduct. I understand that all client information is strictly confidential.

Signature: _____ Print Name: _____