



# ABI HARPER MASSAGE THERAPY

## CLIENT RECORD

Please print clearly and complete both sides of this form. This information is critical to your treatment, as it may affect the structure and focus of your session. All information disclosed will be kept strictly confidential.

Name:  Date:

Phone:  Email Address:

Address:   
Street

Check here if you do not wish to be added to my low-traffic announcement list.

City State Zip

Date of birth:  Occupation:

What is your main physical activity at work?

On phone Computer work Lifting Sitting Standing Driving

Other:

Please describe your exercise habits:

Have you ever had therapeutic massage before?

Yes No Many times

Please circle any painful or tense areas, as well as regions where you tend to hold your stress:

Frequent headaches Backaches Tense shoulders/Stiff neck Upset stomach

Leg/foot cramps Other:

Please describe any recent injuries or medical conditions:

Please list any medications that you take:

## GENERAL MEDICAL SIGNS AND SYMPTOMS

Please indicate if you currently have any of the following conditions

Symptom	Yes	No	Location: Please describe
1. Any areas of infection?			
2. Any areas of swelling, edema or tendency to swell?			
3. Any areas of numbness or abnormal sensation?			
4. Any areas of pain or tenderness?			

## SPECIFIC MEDICAL CONDITIONS

For your safety, I must be aware of all medical conditions for which you have been diagnosed.  
Therapeutic massage may impact these and your health.

Symptom	Yes	No	Location: Please describe
5. Arthritis:			
6. Cancer or Tumors:			
7. Cardiovascular diseases: Please circle all that apply	Anemia                      Angina                      Arteriosclerosis                      Congestive Heart Failure Heart Attack                      Heart Murmur                      Hemophilia Hypertension/High blood pressure                      Varicose or Spider Veins Other:		
8. Diabetes:			
9. Injuries:			
10. Kidney or Liver Disease:			
11. Respiratory or Lung conditions:			
12. Skin conditions: Please circle all that apply	Acne                      Abrasions / Cuts                      Bruises                      Dermatitis                      Eczema                      Herpes Hives                      Poison ivy/oak/sumac                      Psoriasis                      Skin tags                      Sunburns Warts                      Other:		
13. Other medical conditions:			

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. If I experience any pain during this session, I will immediately inform the practitioner so that the work can be adjusted to my level of comfort.

I further understand that massage/bodywork should not be used 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 that I am aware of.

Because massage can be harmful 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 forget to do so.

It is also understood 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 for the full scheduled appointment.

Should I need to cancel future sessions, I agree to give my practitioner 24 hours notice or I will be financially responsible for the session time.

Signed:  Date: