Name: _____

Date: _____

Body Work: Massage, Reflexology, Shiatsu

List Medications and Supplements:

_____

_____

Check the box to indicate any medical conditions you currently have:

- ☐ Pregnancy
- ☐ Cancer
- ☐ Heart/circulation problems
- ☐ Recent accident/surgery
- ☐ Neck/back injuries
- ☐ Numbness or Swelling
- ☐ Allergies
- ☐ Headaches or TMJ
- ☐ Depression or Anxiety
- ☐ Varicose veins
- ☐ Diabetes
- ☐ Sprains/strains
- ☐ Arthritis/tendonitis
- ☐ Immune Disorders
- ☐ High/low blood pressure
- ☐ Blood clots
- ☐ Fibromyalgia
- ☐ Osteoporosis

Are you pregnant? Yes/No

Explain any conditions you have marked above:

_____

_____

_____

_____

Do you have sensitivity to? _____Touch _____Cold or Heat _____Dry or Damp

Are you wearing? _____Contact lenses _____Hearing Aides _____Dentures _____IUD _____Pacemaker

Have you had any? Surgeries _____Injuries _____Other conditions not listed?

Personal Issues of Concerns?

(List and rate your issues/concerns on a scale of 0-5 (0- no issue, 5- worse)

	Issues	Rating
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Your Signature below indicates you have provided accurate information.

Client Signature: _____ **Date**: _____

Client Printed Name: _____