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EASTERNHEALTHWAY
ACUPUNCTURE & MASSAGE
697 CAMBRIDGE STREET, SUITE 202
BRIGHTON, MA 02135
TEL: 617-309-9901

Massage Client Information Form

Date _____

Name	DOB	Gender ☐M ☐F
Address		
City	State	Zip
Phone	Email	Occupation
I prefer receive appointment reminder by ☐ Phone ☐ Email ☐ No need to remind me		
Emergency Contact	Contact Number	
Referred by		

MEDICAL INFORMATION

☐ Yes ☐ No *Have you had a massage before? If yes, how recently?* _____
☐ Yes ☐ No *Do you frequently suffer from stress?*
☐ Yes ☐ No *Do you have diabetes?*
☐ Yes ☐ No *Do you experience frequent headaches?*
☐ Yes ☐ No *Are you pregnant?*
☐ Yes ☐ No *Do you suffer from arthritis? Where:* _____
☐ Yes ☐ No *Are you wearing dentures?*
☐ Yes ☐ No *Do you have high blood pressure? If yes, do you take medication? Yes / No*
☐ Yes ☐ No *Do you suffer from epilepsy or seizures?*
☐ Yes ☐ No *Do you suffer from joint swelling? Where:* _____
☐ Yes ☐ No *Do you have varicose veins?*
☐ Yes ☐ No *Do you have any contagious diseases?*
☐ Yes ☐ No *Do you have osteoporosis?*
☐ Yes ☐ No *Do you have any allergies?*
☐ Yes ☐ No *Do you have any skin conditions?*
☐ Yes ☐ No *Do you bruise easily?*
☐ Yes ☐ No *Have you had any broken bones in the past two years? Please list:* _____
☐ Yes ☐ No *Have you been in an accident or suffered any injuries in the past two years? Please explain on back.*
☐ Yes ☐ No *Do you have cardiac or circulatory problems?*
☐ Yes ☐ No *Do you suffer from neck or back pain?*
☐ Yes ☐ No *Do you have numbness or stabbing pains anywhere?*
☐ Yes ☐ No *Are you very sensitive to touch or pressure in any area?*
☐ Yes ☐ No *Have you ever had surgery? Please explain:* _____
☐ Yes ☐ No *Do you have, or have you ever had, cancer?*
☐ Yes ☐ No *Do you have any other medical condition or are you taking any medications I should know about?*

_____

☐ Yes ☐ No *Do you have tension or soreness (including sprains/strains) in a specific area? Please specify:*

_____

☐ Yes ☐ No *Do you exercise? Please list activities, frequency, and intensity:*

_____

☐ Yes ☐ No *Do you have other concerns your massage therapist should be aware of? Please explain:*

_____

Over please