

# Leia Davis, LMT

#MA61335377

# Health Information

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## Client Contact Information

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes  No

## Massage Information

Have you ever received massage/bodywork before? Yes  No

How recently? \_\_\_\_\_

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

\_\_\_\_\_

Are you struggling with any daily activities – work, exercise, house work, yard work, etc.

\_\_\_\_\_

Are you currently experiencing any of the following? If yes, please explain.

Numbness or tingling No  Yes  \_\_\_\_\_ Swelling No  Yes  \_\_\_\_\_

Allergies (epi pen?) No  Yes  \_\_\_\_\_

List all illnesses, injuries, and health concerns you have now or have had in the past 3 years. Especially anything that could affect treatment. (Examples: surgeries, arthritis, diabetes, car crash, pregnancy, circulatory, etc)

\_\_\_\_\_  
\_\_\_\_\_

List all medications and pain relievers you've taken this week, and why you take them:

\_\_\_\_\_  
\_\_\_\_\_

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**Health History**

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please answer honestly, as massage may not be indicated for the above conditions.

Please check conditions that you have or have had in the past. Explain in detail, including treatment received:

- Bruise easily \_\_\_\_\_
- Sensitive to touch/pressure (e.g. MPS, fibromyalgia) \_\_\_\_\_
- High/Low blood pressure \_\_\_\_\_
- Stroke, heart attack \_\_\_\_\_
- Varicose veins \_\_\_\_\_
- Shortness of breath, asthma \_\_\_\_\_
- Cancer \_\_\_\_\_
- Neurological (e.g. MS, Parkinson's, chronic pain) \_\_\_\_\_
- Epilepsy, seizures \_\_\_\_\_
- Headaches, Migraines \_\_\_\_\_
- Dizziness, ringing in ears \_\_\_\_\_
- Digestive conditions (e.g. Crohn's, IBS) \_\_\_\_\_
- Gas, bloating, constipation \_\_\_\_\_
- Kidney disease, infection \_\_\_\_\_
- Arthritis (rheumatoid, osteoarthritis) \_\_\_\_\_
- Osteoporosis, degenerative spine/disk \_\_\_\_\_
- Scoliosis \_\_\_\_\_
- Broken bones \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Endocrine/thyroid conditions \_\_\_\_\_
- Depression, anxiety \_\_\_\_\_
- Memory Loss, confusion, easily overwhelmed \_\_\_\_\_

Comments:

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**Consent for Treatment**

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