Lisa L. Konietzky, LMT
Licensed Massage Therapist

MA#31424

Date_____

CONFIDENTIAL CLIENT INFORMATION

Name:_____DOB:_____Email:_____

Address:_____Months/Years:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Employer:_____Occupation:_____

In case of emergency, who can we contact:

Name:_____Relationship:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

How did you find out about our services? Please check the appropriate item(s).

☐ Referral ☐ Facebook ☐ Instagram ☐ LinkedIn ☐ Twitter ☐ Publication

Other_____

Have you ever received a massage prior to this visit? ☐ Yes ☐ No

If yes, would you recommend it to others? ☐ Yes ☐ No

What is the reason, purpose, expectation, or goal of your visit?

☐ Basic Relaxation ☐ Physician Recommendation ☐ Other_____

MEDICAL AND PHYSICAL INFORMATION

☐ Abscess
☐ Allergies
☐ Arteriosclerosis
☐ Asthma
☐ Athlete's foot
☐ Back injury
☐ Bowel problems
☐ Cancer/malignancy
Type_____
☐ Diabetes
☐ Dizziness
☐ Easy bruising
☐ Edema
☐ Epilepsy
☐ Fatigue
☐ Fibrositis
☐ Hearing problems
☐ Hearing aid
☐ Heart disease
☐ Herniated disc
☐ Herpes I or II
☐ High/low blood pressure
☐ Hypertension
☐ Indigestion
☐ Inner ear problems
☐ Insomnia
☐ Medications
_____
_____
☐ Mental illness
☐ Muscle sprain/strain
☐ Numbness
☐ Osteoarthritis
☐ Osteoporosis
☐ Other injury_____
_____
☐ Other respiratory problems
☐ Other surgery_____
_____
☐ Phlebitis
☐ Pregnancy
No. of months_____
☐ PMS/painful menstruation
☐ Poor memory
☐ Rheumatoid arthritis
☐ Scoliosis
☐ Sensitive skin
☐ Skin rashes/inflammation
☐ Speech problems
☐ Varicose veins
Where? _____
☐ Wearing contact lenses
☐ Wearing dentures

How long ago did you have the item(s) that you checked and please list all medications._____

_____

_____

If you are being treated by any of the following, please indicate:

☐ Physician ☐ Chiropractor ☐ Physical Therapist ☐ Psychotherapist

☐ Other_____

Please list specific information about the professionals listed above. This information is important in the event we must consult the person(s) about the techniques used in your massage sessions, your safety, or your well-being.

Name of Professional	Office Location	Office Phone Numbers

Do you participate in any exercise programs or sports? ☐ Yes ☐ No

If yes, which ones:_____

Do you practice any body-related relaxation techniques? ☐ Yes ☐ No

Are there any areas that you find very sensitive or difficult to be touched? ☐ Yes ☐ No

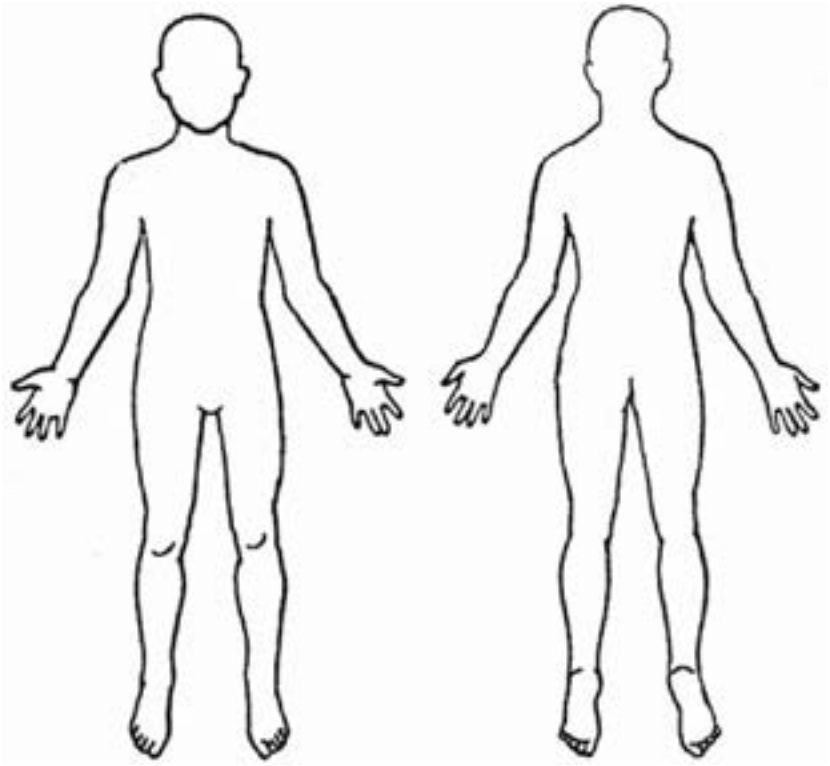
If yes, which ones:_____

Do you have specific areas where you hold tension? ☐ Yes ☐ No

Are you experiencing any areas of pain? ☐ Yes ☐ No

Please indicate on the Pain Assessment Person Chart below:

FRONT **BACK**



Extreme Pain

☐ 10
☐ 9
☐ 8
☐ 7
☐ 6
☐ 5
☐ 4
☐ 3
☐ 2
☐ 1
☐ 0

No Pain