



DIAMOND WILLOW MASSAGE & BODYWORK

MELIS ARIK, CERTIFIED MASSAGE THERAPIST

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(612) 384-4122

Today's Date: _____

NEW CLIENT INFORMATION

Name _____ Referred by: _____

Address _____

City _____ State _____ Zip: _____ Birthdate ____/____/____

Phone (home) _____ (work) _____

Email Address _____

EMERGENCY CONTACT: _____ Phone _____

PHYSICIAN/clinic: _____ Phone: _____

May I keep you informed of specials or other information by email? Yes No

GOALS FOR THIS SESSION:

Have you received massage in the past? Yes No

When was your last massage? _____

Please mark with an X and describe any of the following statements that are true today:

___ I feel pain in my body or part of my body aches.

___ Part of my body feels stiff or feels less flexible than usual.

___ I'm working out/exercising/using my body more intensely than usual.

___ I feel more stressed-out than usual.

MEDICAL HISTORY

General Health: ___ Excellent ___ Good ___ Poor

- Medications and supplements: _____
- Do you have or have you had any contagious skin condition (such as warts, athlete's foot, chicken pox, etc)?
Yes No If yes, describe: _____

- Please list any drug allergies or other allergies/sensitivities (scents, nuts, pollen, pets, etc): _____
- Circle if you wear: contact lenses dentures
- **Are you pregnant?** Yes No **If yes, how many weeks?** _____ Due date? _____

PAST or PRESENT MEDICAL CONDITIONS – Check all that apply & circle if past or present

___ Sciatica	past	present	___ TMJ/clenching jaw	past	present
___ Disc/spine problems	past	present	___ Headaches	past	present
___ Scoliosis	past	present	___ Grinding teeth	past	present
___ Osteoporosis	past	present	___ Sinus trouble	past	present
___ Arthritis	past	present			
			___ Hepatitis	past	present
___ Cancer	past	present	___ HIV/AIDS	past	present
___ Diabetes	past	present	___ TB	past	present
___ Seizures	past	present			
			___ Heart palpitations	past	present
___ Fibromyalgia	past	present	___ Heart disease	past	present
___ Chronic Fatigue Syndrome	past	present	___ High/low blood pressure	past	present
___ Difficulty sleeping	past	present	___ Stroke	past	present
___ Depression	past	present	___ Varicose veins	past	present
___ Ulcers	past	present			
___ Asthma	past	present			

Notes: _____

ACCIDENTS AND INJURIES

Have you ever been in a car, motorcycle, or bike accident?

(1) Date	What happened	Injuries
_____	_____	_____

(2) Date	What happened	Injuries
_____	_____	_____

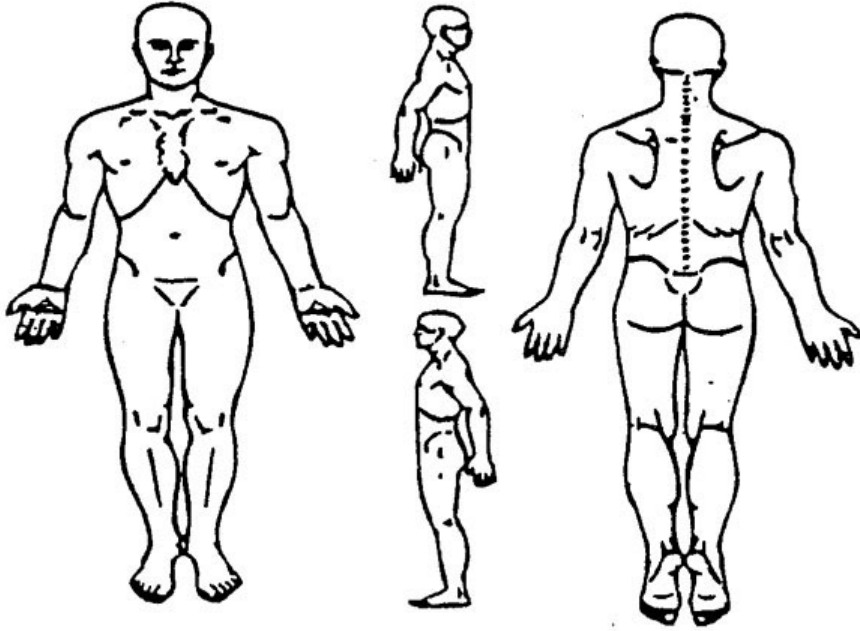
Please describe any other accidents or injuries over the years (broken bones, sprains, strains, major cuts, etc):

Date	What happened	Injuries
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS/SURGERIES

Dates

Diagnosis/Operation



Please mark the areas that you would like for me to work on or address in this session.

SELF-CARE & EXERCISE HABITS

What is your occupation? _____

What percentage of your day do you spend: sitting _____% standing _____% walking _____%

What other actions or motions are required in your job? _____

Do you sleep on your back, side, or stomach? _____

Please describe your exercise habits or routines:

Type of exercise _____ How often and for how long? _____

Type of exercise _____ How often and for how long? _____

Do you do any limbering activities in the morning or before exercise ? Yes No

Do you stretch your body after exercising or have a regular stretching routine ? Yes No