

**CONFIDENTIAL CLIENT INTERVIEW**

**LIFETIME THERAPEUTIC MASSAGE**

Date

Name

Date of Birth

Address

Day Phone & ext

City,State,Zip

Night Phone & ext

Email

May we email you occasionally with news & specials? Yes No

How did you hear about Lifetime Therapeutic Massage?

My therapist gave me a copy of LTM's office policies, and I understand that my therapist is a sole proprietor and not an employee of Lifetime Therapeutic Massage\_\_\_\_\_ (initial)

What are your goals for this session?

Have you ever had a massage before? Yes No

Have you ever had an allergic reaction to massage lotions or oils? Yes No

Do you have an allergy to almonds or other nuts? Yes No

List current prescription medications & condition to which they apply:

Over-the-counter medications including aspirin, herbs, vitamins, etc.:

Please mark all that apply with an X for CURRENT, a C for CHRONIC, and a P for PAST history.

**Abdominal**

\_\_\_constipation

\_\_\_diarrhea

\_\_\_hernia

\_\_\_other

\_\_\_swelling/edema

\_\_\_thoracic outlet syndrome

\_\_\_tumor

**Head/Face/Neck**

\_\_\_contact lenses

\_\_\_dental bridges, braces

\_\_\_headaches

\_\_\_hearing problems/deafness

\_\_\_injuries to face or head

\_\_\_jaw pain, TMD ("TMJ")

\_\_\_migraines

\_\_\_sinus problems

\_\_\_vision problems

\_\_\_numbness/tingling

\_\_\_sciatica

\_\_\_sleep difficulties

\_\_\_spinal column disorders

\_\_\_tension/stress

**Circulatory**

\_\_\_blood clot

\_\_\_heart problems

\_\_\_high/low blood pressure

\_\_\_other

\_\_\_varicosities

**Pain**

\_\_\_chronic pain

\_\_\_joint pain

\_\_\_lower back pain

\_\_\_muscle pain

\_\_\_upper back pain

**Disease/syndromes/immunity**

\_\_\_allergies/sensitivities

\_\_\_arthritis

\_\_\_athlete's foot

\_\_\_cancer

\_\_\_carpal tunnel

\_\_\_diabetes

\_\_\_fibromyalgia/CFS

\_\_\_HIV

\_\_\_infectious disease

\_\_\_kidney disease

\_\_\_rash

**Injuries/Surgery**

\_\_\_bone injuries

\_\_\_muscle injuries

\_\_\_sprains/strains

\_\_\_surgeries

\_\_\_tendonitis

**Respiratory**

\_\_\_asthma

\_\_\_other lung conditions

**Women**

\_\_\_birth control, IUD

\_\_\_perimenopause/menopause symptoms

\_\_\_pregnancy

\_\_\_problem menses

**Nervous systems**

\_\_\_depression

\_\_\_fatigue