Breath Body Works, LLC

Providing effective therapeutic body work since 1988.

New Client History Form/Pain and Discomfort Chart

In order to maximize the effectiveness and safety of massage sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Your feedback is appreciated during and at the end of the sessions to help in tailoring your massage session. Please print clearly.

Name: _____ Today's Date: ____ / ____ / ____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Date of birth: _____ Age: _____ Male ❑ Female ❑ Marital Status: _____

Email Address(es): _____

Occupation: _____ Referred by: _____

1. Have you had any previous experience with massage? Yes ❑ No ❑

If yes, please explain whether for stress relief/relaxation or treatment of a specific condition diagnosed by a physician. _____

_____

2. Do you have high blood pressure? Yes ❑ No ❑ I'm not sure ❑

3. Do you have any cosmetic body implants? Please circle location. Face Buttocks Breast

4. Female Clients: Are you pregnant? If so, how many weeks? _____

5. Please check all the conditions that apply.

❑ headaches, migraines
❑ vision problems, contact lenses
❑ injuries to face or head
❑ sinus problems
❑ dental bridges, braces
❑ jaw pain, TMJ problems
❑ asthma or lung conditions
❑ constipation, diarrhea
❑ hernia
❑ decreased range of motion
❑ chronic/severe pain
❑ muscle or joint pain
❑ muscle, bone injury
❑ numbness or tingling
❑ sprains, strains, dislocations
❑ arthritis, bursitis, gout
❑ cancer, tumors
❑ spinal column disorders
❑ diabetes
❑ heart, circulatory problems
❑ stroke
❑ fibromyalgia
❑ sleep difficulties
❑ open cuts, burns
❑ allergies, sensitivity
❑ skin rash, athletes foot
❑ infectious disease
❑ blood clots
❑ varicose veins
❑ other medical conditions not listed: _____

PLEASE CONTINUE TO THE NEXT PAGE

6. Explain any areas noted above and if you are currently being treated by a doctor.

_____

_____

_____

7. List all prescription medications you are taking.

_____

_____

_____

8. List all over the counter medications. This includes vitamins, herbs, and mineral supplements.

_____

_____

9. Have you had any surgeries within the past 5 years? If so, please explain.

_____

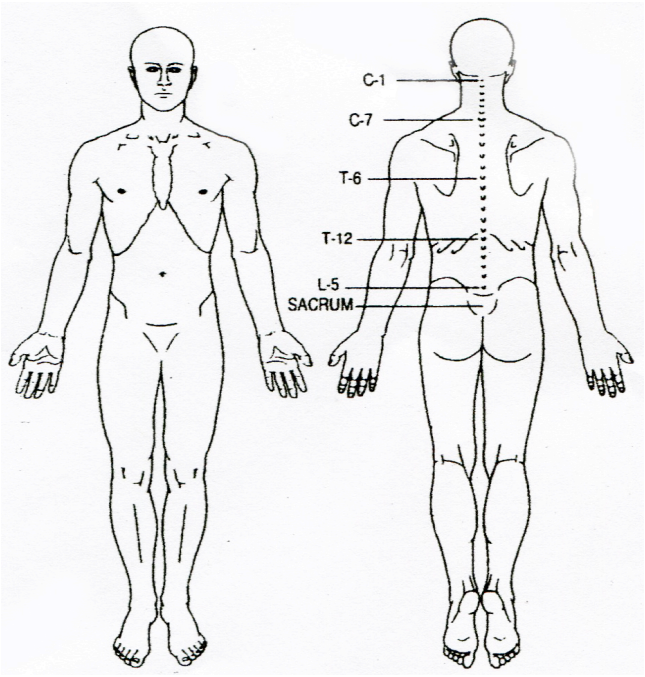
_____

11. What is your goal or concern for today's session? _____

_____

PAIN & DISCOMFORT CHART

1. Please indicate the areas where you have pain and describe the level of discomfort using a scale of 1 – 10. (*A score of 1 being almost no pain and 10 being the highest level of discomfort.)* If your pain seems to refer or "shot out" to another area of your body please indicate with arrows.



2. For how long have you experienced pain/discomfort in the areas indicated above?

_____

3. Describe what you do that causes pain and what activities make it worse: _____

_____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

- I understand that massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

Date: _____ Signature: _____