Michele Ruppert Therapeutic Massage-Bodywork
http://www.micheleruppert.com/

Confidential Client Information Form

Name: ______________________________ Date: ______________
Full Address: ____
Phone: Home: ______________ Work: ______________ Mobile: ______________
Date of Birth: ________________ Occupation: ____________________
Referred by: __________________ Email Address: ____________________

Confidential Health History

Are you currently under medical care or taking any medications? If so, what?

____
____
____
____

Please provide additional information as necessary (approximate dates, frequency, etc.) to clarify the condition(s) from items checked on the next page.

____
____
____
____

List any other present and past accidents, injuries, major illnesses, hospitalizations, surgeries, etc. that has not been identified. Provide additional details as necessary.

____
____
____
____

Do you have any sensitive areas (i.e. ticklish, numbness over scars) that could affect your session? If so, what? ____
____
____
____

To the best of my knowledge I have accurately disclosed my present and past health conditions. This information will be kept in confidence and is vial to the appropriateness of the sessions designed by my massage therapist. I agree to inform my massage therapist if any concerns arise during the massage. I understand that this massage and therapy is not intended as medical treatment or psychological treatment.

Signature: ______________________________ Date: ________________`

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Confidential Health History

Check the following conditions that apply to you, past and present. Please provide additional information as necessary to the backside of this document to clarify the condition.

Musculo-Skeletal
o Headaches
o Joint stiffness/swelling
o Spasms/cramps
o Broken/fractured bones
o Strains/sprains
o Back, hip pain
o Shoulder, neck, arm, hand pain
o Leg, foot pain
o Chest, ribs, abdominal pain
o Problems walking
o Jaw pain/TMJ
o Tendinitis
o Bursitis
o Arthritis
o Osteoporosis
o Scoliosis
o Bone or joint disease
o Gout
o Other: ____________________

Circulatory and Respiratory
o Dizziness
o Shortness of breath
o Fainting
o Cold feet or hands
o Cold sweats
o Swollen ankles
o Pressure sores
o Varicose veins
o Blood clots
o Stroke
o Heart condition
o Allergies
o Sinus problems
o Asthma
o High blood pressure
o Low blood pressure
o Lymphedema
o Other: ____________________

Skin
o Rashes
o Allergies
o Athlete's Foot
o Warts
o Moles
o Acne
o Cosmetic surgery
o Other: ____________________

Digestive
o Nervous stomach
o Indigestion
o Constipation
o Intestinal gas/bloating
o Diarrhea
o Diverticulitis
o Irritable bowel syndrome
o Crohn's Disease
o Colitis
o Adaptive aids
o Other: ____________________

Nervous System
o Numbness/tingling
o Twitching of face
o Fatigue
o Chronic pain
o Sleep disorders
o Ulcers
o Paralysis
o Herpes/shingles
o Cerebral Palsy
o Epilepsy
o Chronic Fatigue Syndrome
o Multiple Sclerosis
o Muscular Dystrophy
o Parkinson's disease
o Spinal cord injury
o Other: ____________________

For clients who need mobility assistance, please give your height: ________ weight: ________

Reproductive System
o Pregnancy:
  o Current
  o Previous
o Menstrual cycle problems
o PMS
o Menopause
o Pelvic Inflammatory Disease
o Endometriosis
o Hysterectomy
o Fertility concerns
o Prostate problems

Other
o Loss of appetite
o Forgetfulness
o Confusion
o Depression
o Hopelessness
o Anxiety and Tension
o Difficulty concentrating
o Drug use __________________
o Alcohol use _______________
o Nicotine use _______________
o Caffeine use _______________
o Hearing impaired
o Visually impaired
o Burning upon urination
o Bladder infection
o Eating disorder
o Diabetes
o Hypoglycemia
o Hypo/Hyper Thyroidism
o Fibromyalgia
o Post/Polio Syndrome
o Cancer
o Infectious disease (please list)
____
o Other congenital or acquired disabilities (please list) _______
____
o Other: ____________________