Libertyville Massage Therapy Clinic, Inc.

128 Newberry Avenue
Libertyville, Illinois 60048
(847) 680-0077

Confidential Client Information

Name_____ Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Email_____ Cell Phone _____

Age_____ Birthdate_____ Todays Date_____

Occupation_____

Employer_____ Address_____

How were you referred to our clinic?_____

Please check if you presently have or have had in the past, any of the following conditions:

MUSCULO-SKELETAL

Bone Cancer		Nerve Damage		Muscle Problems:	
Fracture(s)		Other Spinal Problems		*Tear	
Bone Spur		Osteoporosis		*Strain	
Disc Problems:		Arthritis		*Sprain	
*Herniation		*Osteo-		*Spasm	
*Degeneration		*Osteo-		*Tightness	
*Fusion		TMJ Syndrome		Recent Injury:	
*Removal		Sciatica		Other	
*Slipped		Fibrositis/Fibromyalgia			

CIRCULATORY/CARDIOVASCULAR

Heart Disease		Aneurysm		Heart Murmur	
Heart Attack		Blood Clot		Varicose Veins	
Stroke		High Blood Pressure		Other:	

SKIN

Athlete's Foot		Open Sore/Cuts		Heat/Cold Sensitivity	
Rash		Infectious Conditions		Ticklishness	
Psoriasis/Eczema		Burn(s)		Other:	

IMMUNE

AIDS		Epstein Barr's Disease		Other:	
Cancer		Tumor			
Leukemia		Cyst			

*We reserve the right to charge for missed appointments and appointments cancelled without a 24 hour cancellation notice.

(Continued)

NERVOUS

Epilepsy		Convulsion/Seizure		Nerve Damage	
Headache		Dizziness/Fainting		Other:	

DIGESTIVE

Colitis		Kidney/Bladder Infect.		Weak Bladder	
Ulcer		Kidney/Gall Stones		Constipation/Diarrhea	
Hepatitis		Blood in Urine/Stool		Other:	

RESPIRATORY

Lung Cancer		Pneumonia		Difficulty Breathing	
Emphysema		Cold/Flu		Allergies (please list):	
Asthma		Fever			
Bronchitis		Smoker			

REPRODUCTIVE

Pregnancy		Tumor		Sexually Tran Disease	
Cancer		Cyst		Other:	

ENDOCRINE/LYMPHATIC

Gland Disorder		Diabetes		Hormone/Chemical Imbalance	

BRAIN/NEUROLOGICAL

Depression		Anxiety		Alcohol/Drug Abuse	
Nervousness		Brain Disorder		Other:	

OTHER

Contact Lenses		Caffeine		Alcohol/Drugs	
Dentures		Nicotine		Aspirin/Advil	

Please list any other medical conditions the therapist should be aware of:

_____

Is a physician treating you for this problem? If so, please list the physician's name:

_____

Please list areas of specific pain, tightness, stress or tension:

_____

Please list any medications you are taking:

_____

Have you ever received a professional massage before?

_____

In what ways do you hope to benefit from massage therapy?

_____

I understand that the massage therapy treatment I will receive is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder, or prescribe medical treatment or pharmaceuticals; nor does the therapist perform any spinal manipulations. I understand that massage therapy is not a substitute for a medical examination and diagnosis, and that it is recommended that I see a physician for any physical condition I might have. As requested above, I have stated all my known medical conditions and will make known to the therapist any new medical conditions that might arise. In accordance with all of the above, I agree to have massage therapy treatment and hold the therapist harmless for any problems that might arise as a result of massage.

Client Signature:_____ Date_____