CONNECTION STUDIO
Confidential Client Information and Health History

First Name_____ M.I._____ Last Name_____

Address:_____ City:_____ State:_____ Zip:_____

Phone (h)_____ (c)_____ Birth Date__/____/____ Age:_____

Email Address:_____ Marital Status_____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship _____

Do you wear contacts? ____ Do you exercise? _____ If yes, how? _____

How much water do you drink in a day? _____ Do you consider yourself stressed? _____

Is this your first professional massage? ____ If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage? _____

Are you aware of any tension holding spots in your body? _____ If yes, where? _____

Describe <u>any</u> surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel you have recovered from these events? _____ Please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis?_____ Please explain:

_____

Describe what activities cause this pain and/or make it worse: _____

_____

Are you currently receiving any other type of medical or therapeutic treatment? ____ Please explain:

_____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals. Include an explanation of what the medication is used to treat: _____

Are you currently under the care of a physician? _____ Whom? _____

Please list reasons: _____

Are there any health concerns you wish to discuss today? _____ If yes, please describe _____