Progressive Laser LLC

"Science enhancing Beauty..."

Client Massage Record

Your answers to the following questions will be kept confidential.
They will be seen only by the therapist(s) and are requested so that better care may be provided to you.
Payment is due at the time service is rendered. 24 hour notice is expected for cancellations or fees will be applied.

Today's Date: _____ Email Address: _____

Client Name: _____

Address: _____

City:_____ State:_____ Zip: _____

Daytime Telephone:_____ Evening Telephone: _____

Age :_____ DOB:_____ Sex: _____

Currently Pregnant? _____ Contact Lenses? _____ Hearing Aid? _____

What is the nature/type of work you do regularly? _____

What do you do for exercise? _____

What do you do for relaxation? _____

How did you learn about us? (Website, Yellow Pages, Friend, Dr., P.T., D.C., Etc.):_____

Have you received massage before? _____

If yes, what kind? ☐ Swedish ☐ Deep Tissue ☐ Integrative ☐ Not Sure ☐ Other

Reason(s) for coming in for Massage:
☐ Relaxation/Stress Reduction ☐ Pain ☐ Feels Great

☐Part of Recovery ☐ Injury Date of Accident: _____

☐ Other Reason:_____

Specific areas or issues you want addressed during the session: _____

Allergies (food/inhalant/contact)? _____

Drugs/Medicine taken in the last 2 weeks (Prescription/OTC/Recreational): _____

How are you feeling in your body today? _____

Please describe any symptoms you are experiencing (location, intensity, frequency, duration and onset):_____

_____

_____

Which activities relieve your symptoms?

_____

_____

Which activities aggravate your symptoms?

_____

_____

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

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

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

Skin
- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other: _____

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

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

Reproductive System
- ☐ Pregnancy:
  - ☐ Current
  - ☐ Previous
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Prostate problems

Other
- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Drug use _____
- ☐ Alcohol use _____
- ☐ Nicotine use _____
- ☐ Caffeine use _____
- ☐ OTC pain relievers _____
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Burning upon urination
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ Infectious disease (please list)_____ _____
- ☐ Other congenital or acquired disabilities (please list) _____
- ☐ Surgeries _____
- ☐ Other: _____

Please list any additional comments regarding your health and well-being:

_____

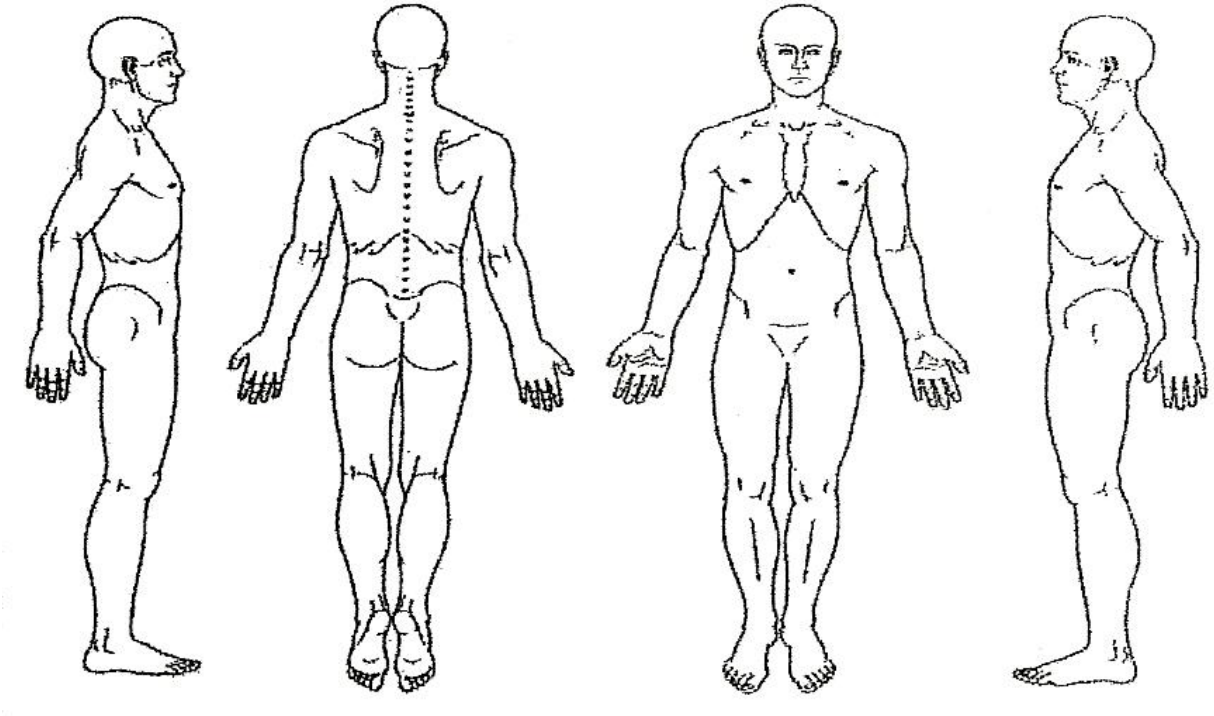
_____

_____

_____

_____

On the images below, please circle specific areas where you are **currently** experiencing pain, discomfort, lack of strength or mobility



Health Care Providers from whom you are currently receiving care:

Practioner's Name	Field of Practice	City/State	Phone

Is there anything else the therapist should know? _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status. I understand that the services provided are not a replacement for medical or psychological care and that any information given to me is not prescriptive or diagnostic in nature and is for educational purposes only. I also give my permission for the LMT(s) with whom I work to discuss information pertinent to my condition(s) and treatment, with my other health care providers.

Client Signature:_____ Date: _____