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# Massage Therapy Client Information

# Welcome to Cleveland State University's Campus Recreation Center!

Thank you for your interest in CSU Rec's Massage Therapy Services! We want to help you reach your health and wellness goals by pairing you up with one of our Licensed Massage Therapists. Please take a moment to review and fill out the following information:

- Massage Therapy Health History Form
- Massage Therapy Informed Consent Form

Questions regarding Massage Therapy Services at
Cleveland State University Campus Recreation Center can be directed to:
**Haley Ross**, Coordinator, Recreation Programs
h.e.ross55@csuohio.edu

*All information submitted in this packet will be kept confidential. Client information regarding health history in any form may only be accessed by appropriate staff of Cleveland State University Campus Recreation Services. Appropriate staff may include, but is not limited to, your Licensed Massage Therapist and the Coordinator - Recreation Programming.

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# Massage Therapy Health History

**Client Information**

Name: _____Date of Visit: _____

Date of Birth: _____ Gender: Male / Female

Height: _____ Weight: _____

E-mail: _____ Phone Number:_____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Phone Number: _____

**How did you find out about us? Please check all that apply:**

☐ Website ☐ Poster/Flyer ☐ e-newsletter

☐ Program Guide ☐ On Campus Demonstrations

☐ Referred by: _____

☐ Other: _____

If referred by a care provider, may we share health information with them?

Yes/No

What current problem, if any, brings you in today?

_____

_____

What have you done up to now to try to help this problem?

_____

_____

Type of Massage: ☐ Swedish ☐ Sport ☐ Deep Tissue

Length: ☐ 30 min ☐ 60 min ☐ 90 min

**Availability**

Please provide three days and time frames that you would be available for the service.*

1. Day: _____ Time frame: _____

2. Day: Time frame: _____

3. Day: _____ Time frame: _____

*Please be aware that while we will make every effort to accommodate the provided times, we cannot guarantee that a Massage Therapist will be available to meet your exact schedule. Thank you in advance for your understanding.

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# Massage Therapy Health History

## Have you noticed any of the following signs or symptoms?

Check the appropriate box(es) at the right if you've observed the sign, concern or symptom.

| | Noticed Lately | Noticed in the Past |
|---|---|---|
| Skin Allergies | ☐ | ☐ |
| Open Cuts or Sores | ☐ | ☐ |
| Skin Infection/ Inflammation | ☐ | ☐ |
| Bruise Easliy | ☐ | ☐ |
| Muscles That Ache At Rest | ☐ | ☐ |
| Places Sore When You Touch Them | ☐ | ☐ |
| Puffy or Swollen Areas | ☐ | ☐ |
| Aching Joints | ☐ | ☐ |
| Cramps | ☐ | ☐ |
| Knots or Lumps | ☐ | ☐ |
| Low Back Pain | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |

| | Noticed Lately | Noticed in the Past |
|---|---|---|
| Neck Pain or Tension | ☐ | ☐ |
| Head or Eye Pain | ☐ | ☐ |
| Difficulty Relaxing | ☐ | ☐ |
| Difficulty Sleeping | ☐ | ☐ |
| Always Tired | ☐ | ☐ |
| Difficulty Breathing | ☐ | ☐ |
| Airborne/Seasonal Allergies | ☐ | ☐ |
| Bloating | ☐ | ☐ |
| Others, please list: | | |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

## What, if any, activities, movements, or position are uncomfortable or difficult

| Describe the activity, movement or position | Date This Started | How Often Do You Notice | How Does It Impact You? | Have You Felt This Before? |
|---|---|---|---|---|
| | | | LOW / MODERATE / HIGH ◯ ◯ ◯ | YES / NO ◯ ◯ |
| | | | LOW / MODERATE / HIGH ◯ ◯ ◯ | YES / NO ◯ ◯ |
| | | | LOW / MODERATE/ HIGH ◯ ◯ ◯ | YES / NO ◯ ◯ |
| | | | LOW / MODERATE / HIGH ◯ ◯ ◯ | YES / NO ◯ ◯ |
| | | | LOW / MODERATE / HIGH ◯ ◯ ◯ | YES / NO ◯ ◯ |

What current medications, supplements, or herbs, if any, are you taking?

_____

_____

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# Massage Therapy Health History

## Illness or Other Conditions

| I have or had this condition: | Date This Started | Date Doctor | Troubles You Lately | Date Last Sought Care |
|---|---|---|---|---|
| Arthritis | | | Y / N | |
| Cancer, Other Tumor | | | Y / N | |
| Chronic Fatigue Syndrome | | | Y / N | |
| Diabetes | | | Y / N | |
| Disk Problems (Spine) | | | Y / N | |
| Fibromyalgia | | | Y / N | |
| Heart Disease or Attack | | | Y / N | |
| High/Low Blood Pressure | | | Y / N | |
| Infection or Inflammation | | | Y / N | |
| Migrane Headaches | | | Y / N | |
| Osteoporosis | | | Y / N | |
| Sciatica | | | Y / N | |
| Stroke/CVA/TIA | | | Y / N | |

## Injuries or Surgeries

| Describe Injury/ Incident/ Surgery | Date It Occured | Troubled You Lately |
|---|---|---|
| | | YES/NO |
| | | YES/NO |
| | | YES/NO |
| | | YES/NO |

I understand that my accurate and complete medical history is needed to make decisions about my care. To the best of my knowledge, the above information is accurate and complete, and I will let you know if it changes.

Signature: _____ Date: _____

**FOR OFFICE USE ONLY**

Date: _____ Paid: _____ Sessions: _____ Staff Inititals: _____

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# Massage Therapy Health History

**Please take a moment to carefully read the following information and sign where indicated.**

If you have certain medical conditions or symptoms, massage therapy may be problematic for you. A referral from your primary health care provider may be required prior to treatment being provided.

If at any point during the massage I am uncomfortable or uneasy with the procedures being administered, and/or if I experience pain, I understand it is my responsibility to IMMEDIATELY inform the massage therapist, so that the procedures can be adjusted to a level of comfort or terminated.

I further understand that massage therapy is not a substitute for diagnosis and treatment by a medical or osteopathic doctor. What we discuss is not a replacement for their advice. Please read the following rules about each visit. Your signature below confirms that you agree to:

## Before Each Treatment

- Tell your therapist about any changes in your health since your last visit
- Remove all jewelry. If it is a wedding band or other item that must be left on, please inform your therapist.
- Ask your therapist if it is best to tie up long hair.
- Leave on appropriate undergarments for your safety and comfort.

## Throughout Your Visit

- Please ask questions about the procedures. Your therapist will be happy to keep you informed and comfortable.
- Always inform your therapist immediately upon any pain or discomfort.
- Refrain from making illicit or sexually suggestive remarks or actions. Any such behavior will result in immediate termination of the treatment.

*I agree to provide complete and accurate information about my health history today, and to tell my massage therapist about any changes in the future. If I do not, it may result in the termination of this appointment and any future appointments with Cleveland State University's Campus Recreation Center.*

Patient's Signature: _____ Date:_____

Therapist's Signature: _____ Date: _____