Govea Massage and Wellness
2010 N Tustin St #B
Orange, Ca 92865
(714) 944-8616

Health Information

Client Contact Information

Client Name: _____ Date of Birth: _____ Gender: _____
Address: _____
Phone: _____ Email: _____

Emergency contact: _____ Phone: _____

Referred by: _____

Massage Information

Have you ever received professional massage/bodywork before? ☐ Yes ☐ No
How recently? _____
What types of massage/bodywork do you prefer? _____
What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm ☐ Deep Tissue
What are your goals/expected outcomes for receiving massage/bodywork?
_____
_____
How do you feel today? _____
_____
List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):
_____
_____
Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)?
Explain: _____
_____
List the medications you currently take: _____
_____

Are you pregnant? Yes ☐ No ☐

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?
_____
_____
Please indicate any of the following health conditions that you currently have (If you are unsure, please ask).
Please answer honestly, as massage may not be indicated for the below conditions:
☐ Blood clots ☐ Infections ☐ Congestive heart failure ☐ Contagious diseases ☐ Pitted edema

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Please indicate conditions that you have or have had in the past:

☐ Current	☐ Past	Muscle or joint pain	☐ Current	☐ Past	Headaches, Migraines
☐ Current	☐ Past	Muscle or joint stiffness	☐ Current	☐ Past	Dizziness, ringing in the ears
☐ Current	☐ Past	Numbness or tingling	☐ Current	☐ Past	Digestive conditions
☐ Current	☐ Past	Swelling	☐ Current	☐ Past	Kidney disease, infection
☐ Current	☐ Past	Bruise easily	☐ Current	☐ Past	Arthritis
☐ Current	☐ Past	Sensitive to touch/pressure	☐ Current	☐ Past	Neurological (MS, Parkinson's)
☐ Current	☐ Past	High/Low blood pressure	☐ Current	☐ Past	Scoliosis
☐ Current	☐ Past	Stroke, heart attack	☐ Current	☐ Past	Broken bones
☐ Current	☐ Past	Varicose veins	☐ Current	☐ Past	Allergies
☐ Current	☐ Past	Shortness of breath, asthma	☐ Current	☐ Past	Endocrine/thyroid conditions
☐ Current	☐ Past	Cancer	☐ Current	☐ Past	Memory Loss, confusion
☐ Current	☐ Past	Diabetes	☐ Current	☐ Past	Depression, anxiety
☐ Current	☐ Past	Epilepsy, seizures	☐ Current	☐ Past	Osteoporosis, degenerative spine/disk

Comments: _____
_____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____