REXROAD MASSOTHERAPY
GLENN REXROAD, LMT, NMT
3206 N. MARTADALE DRIVE
AKRON, OHIO 44333
(330) 929-2819

CLIENT HISTORY FORM

SUBMIT FORM

NAME _____ DATE_____SEX: M☐F☐ MARITAL STATUS: S☐D☐M☐

PHONE _____ CELL_____ EMERGENCY # 1) _____ 2) _____

STREET ADDRESS_____CITY_____ST_____ ZIP_____

DATE OF BIRTH_____AGE_____ NO. OF CHILDREN_____ REFERRED BY_____

OCCUPATION_____EMPLOYED BY_____ CO. PHONE_____

WHAT IS YOUR MAJOR COMPLAINT? _____

_____

_____

OTHER COMPLAINTS _____

HOW LONG HAVE YOU HAD THIS CONDITION?_____ WHAT AGGRAVATES IT?_____

_____

IS YOUR CONDITION GETTING WORSE? YES☐NO☐COMES & GOES ☐

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? _____

WHAT DO YOU BELIEVE IS WRONG WITH YOU? _____

_____

_____

HAVE YOU BEEN TO ANYONE ELSE FOR THIS CONDITION? IF YES GIVE NAME _____

DATE_____ RESULTS_____

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? _____ DATE_____ PLEASE DESCRIBE INJURIES _____

_____

_____

LIST ANY PERSONAL INJURY-TYPE ACCIDENTS YOU HAVE HAD AND THEIR DATES (INCLUDE BROKEN BONES/FRACTURES, SPRAINS, STRAINS ETC. _____

_____

_____

LIST ANY SERIOUS ILLNESS YOU HAVE HAD_____

LIST ANY OPERTIONS YOU HAVE HAD AND THEIR DATES_____

_____

LIST ANY MEDICATIONS, VITAMINS, MINERALS, ETC. YOU ARE CURRENTLY TAKING_____

_____

_____

WHEN WAS YOU LAST COMPREHENSIVE PHYSICAL EXAMINATION?_____

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HAVE YOU SUFFERED FROM:

- ☐ Allergy
- ☐ Poor Posture
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Fatigue
- ☐ Sciatica
- ☐ Bruise easily
- ☐ Itching
- ☐ Dizziness
- ☐ Spinal Curvatures
- ☐ Hay Fever
- ☐ Varicose Veins
- ☐ Headache
- ☐ Colon trouble
- ☐ Nose Bleeds
- ☐ Bed Wetting
- ☐ Loss of Sleep
- ☐ Diarrhea
- ☐ Sinus Infections
- ☐ Frequent Urination
- ☐ Ulcers
- ☐ Constipation
- ☐ High Blood Presure
- ☐ Kidney Infections/stones
- ☐ Nervousness
- ☐ Indigestion
- ☐ Low Blood Pressure
- ☐ Prostate Trouble
- ☐ Depression
- ☐ Hemorrhoids
- ☐ Pain over Heart
- ☐ Menstrual Cramps/backache
- ☐ Bursitis
- ☐ Nausea
- ☐ Poor Circulation
- ☐ Excessive Menstrual Flow
- ☐ Foot trouble
- ☐ Asthma
- ☐ Rapid Heart Beat
- ☐ Hot Flashes
- ☐ Low Back Pain
- ☐ Colds
- ☐ Slow Heart Beat
- ☐ Irregular Cycle
- ☐ Neck Pain
- ☐ Stroke
- ☐ Anemia
- ☐ Lumps Breasts
- ☐ Deafness
- ☐ Chest Pain
- ☐ Alcoholism
- ☐ Diabetes
- ☐ Ear Noises
- ☐ Difficulty Breathing
- ☐ Polio
- ☐ Cold sores
- ☐ Enlarged Thyroid
- ☐ Pleurisy
- ☐ Swelling of Ankles
- ☐ Rheumatic fever
- ☐ Eye Pain
- ☐ Swollen Joints
- ☐ Failing Vision
- ☐ Venereal

PAIN/STIFFNESS/TINGLING/NUMBNESS IN:

SHOULDERS ☐ HIPS ☐ HANDS ☐ ARMS ☐ LEGS ☐ KNEES ☐ FEET ☐

I give my permission to receive massage therapy treatments to improve my current health status. I clearly understand and agree that all services provided are charged directly to me and that payment is due at the time of service. I also understand that I am responsible for all health conditions related to this service, and that all information contained on this form is accurate to the best of my knowledge.

SIGNATURE_____ Date _____

SUBMIT FORM