

# CONFIDENTIAL CLIENT

## INFORMATION



First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone(h): \_\_\_\_\_ (w) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred : \_\_\_\_\_ e-mail: \_\_\_\_\_

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Reason for Visit: \_\_\_\_\_

Is this your first professional massage?  Yes  No If no, how frequently do you get a massage? \_\_\_\_\_

Please state **any recent** injuries, surgeries, accidents or medical treatments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please **circle** any of the following conditions you have currently. **Check** any conditions you've had in the past.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Neck/Spine Injury | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Ailment  |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Kidney Ailment |
| <input type="checkbox"/> Sciatica/Leg Pain | <input type="checkbox"/> Skin Disorders      | <input type="checkbox"/> Heart Ailment  |
| <input type="checkbox"/> Carpal Tunnel     | <input type="checkbox"/> Infectious Disease  | <input type="checkbox"/> Fibromyalgia   |
| <input type="checkbox"/> TMJ Syndrome      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer         |
| <input type="checkbox"/> Sport Injuries    | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> PMS Syndrome   |
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Cold/Flu/Fever      | <input type="checkbox"/> Grief Process  |
| <input type="checkbox"/> Varicose Veins    | <input type="checkbox"/> Pregnancy           | Other                                   |

Are you currently under the care of a physician? \_\_\_\_\_ If "Yes" whom? \_\_\_\_\_

Please list reason(s): \_\_\_\_\_

\_\_\_\_\_

Please list any medications taken now or at regular intervals: \_\_\_\_\_

\_\_\_\_\_

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I, also, understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_