Client Information Form

Name____

Address____

City______________________ State______ Zip______________________

Home Phone______________________ Work Phone______________________

Employer______________________________ Occupation______________

Physician____________________ Age_____ Date of Birth______________

Medications you are taking______________________________________

Primary Reason for Appointment__________________________________

Referred by____

Please answer the following questions by circling yes or no answers. Any yes answers will be gone over by you and the massage therapist before your massage.

1. Have you had a professional massage before?	YES	NO
2. Have you ever had surgery?	YES	NO
3. Do you have any spinal problems?	YES	NO
4. Are you pregnant or have an IUD?	YES	NO
5. Do you wear contact lenses or dentures?	YES	NO
6. Do you take any prescribed Medication?	YES	NO
7. Do you have chronic back pain?	YES	NO
8. Do you have frequent headaches?	YES	NO
9. Are you constantly tired?	YES	NO
10. Do you have any heart problems?	YES	NO
11. Do you have high blood pressure?	YES	NO

12. Do you have varicose veins?	YES	NO
13. Do you have or have you had problems with blood clots?	YES	NO
14. Have you ever had cancer?	YES	NO
15. Do you have arthritis?	YES	NO
16. Have you suffered any acute injury?	YES	NO
17. Do you have pain which radiates down legs or arms?	YES	NO
18. Do you suffer from tension?	YES	NO
19. Do you have chronic diarrhea?	YES	NO
20. Do you have chronic constipation?	YES	NO

Do you have any other medical condition of which I should be aware? If so please specify below____

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I, ___________________________________, understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature:________________________________ **Date:**__________________________