

Client Information Form

Name: _____ (Please print clearly) Birthday: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone:(Day) _____ (Eve) _____ Mobile _____

Email: _____ (Please print clearly) I would like to receive newsletters and special offers.

How did you hear about us? _____

Health History

Have you ever had Professional Massage before?	Yes	No		
Do you have any Major Illness?	Yes	No		
Have you had any Major Illness in the past?	Yes	No		
If yes, please describe: _____				
Have you ever had surgery?	Yes	No		
If yes, please describe: _____				
Are you on any medications?	Yes	No		
If yes, please describe: _____				
Are you under a physicians care presently?	Yes	No		
If yes, please describe: _____				
Do you wear contacts or dentures?	Yes	No		
Do you have any skin problems or allergies?	Yes	No		
If yes, please describe: _____				
Do you have varicose veins or blood clots?	Yes	No		
Do you have arthritis?	Yes	No	Rheumatoid Arthritis	Osteoarthritis
Do you exercise regularly?	Yes	No		
If yes, what kind: _____				
Do you have any heart problems?	Yes	No		
Do you have any spinal problems?	Yes	No		
If yes, what is the diagnosis: _____				
Are you pregnant?	Yes	No		
Do you have any jaw injuries or pain?	Yes	No		
If yes, please describe: _____				
Do you have any immune deficiencies?	Yes	No		
If yes, please describe: _____				
Do you have any other medical conditions that I should be aware of before giving you a massage?	Yes	No		
If yes, please describe: _____				

Present Symptoms

What is your major complaint? _____

When did you first notice your major complaint? _____

What activities aggravate the condition? _____

Do you have any minor complaints / other areas of concern? _____

Are you taking any of the following? (please check all that apply)

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Aspirins | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> Minerals |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> Herbs |

Habits: Heavy Moderate Light None (please circle)

Alcohol: <i>H M L N</i>	Coffee: <i>H M L N</i>
Tea: <i>H M L N</i>	Tobacco: <i>H M L N</i>
Exercise: <i>H M L N</i>	Soda/Pop: <i>H M L N</i>
Water: <i>H M L N</i>	

(Over)*

Please mark all that apply: Past or Present

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Tightness of shoulder muscles | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Neuritis in shoulders and arms | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Pins and needles in arms & hands | <input type="checkbox"/> Intestinal gas |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> Tightness in throat | <input type="checkbox"/> T.B. | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Heart pain | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Face flushed | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anemia | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Pins and needles in legs |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Pains in legs and feet |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nerves and nervousness | <input type="checkbox"/> Jaw injuries/problems |
| <input type="checkbox"/> Wear glasses | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Spinal problems |
| <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Irritability | <input type="checkbox"/> Blood clots (family history) |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Immune deficiency syndrome | <input type="checkbox"/> Mono |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Please read before signing:

I understand that the purpose of this massage therapy session is for stress reduction, relief from muscular tension, muscular contraction or spasm(s), for increasing circulation, for tending to ischemic areas or trigger points, or for overall well being.

I understand that the event of any illicit or sexually suggested remarks or advances made by me before or during the scheduled massage session will result in immediate termination of the current therapy session, and I will be liable for payment of the "full" scheduled appointment.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that nothing said in the course of the session(s) given should be construed as such. I understand that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all of my known medical conditions and have 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 practitioners' part should I forget to do so.

Client's printed name: _____

Client's signature: _____

~To avoid a service charge please give 24-hour notice for cancellations.~

Date: _____

Practitioner's signature: _____

Date: _____