CLIENT INFORMATION FORM

Name (please print) _____
Address_____
City_____ State_____ Zip Code_____
Phone (home)_____ (work)_____ (cell)_____
Occupation_____ E-mail Address_____
Age: _____ Birthdate: _____
Referred by:_____
The following series of questions are to familiarize the therapist with important information about you, the client. It is of the utmost importance that you take the time to answer these questions to the best of your ability. This will help the therapist meet your needs with your massage. Please notify your therapist of any changes in your medical condition. All information is confidential.
Primary reason for appointment_____

Have you had a professional massage before?	Yes	No
Do you have any allergies?	Yes	No
Do you have any skin conditions?	Yes	No
Do you have any infectious conditions?	Yes	No
Have you had any surgery?	Yes	No
Do you have any spinal problems?	Yes	No
Do you wear contact lenses or dentures?	Yes	No
Do you experience frequent headaches/migraines?	Yes	No
Are you constantly tired?	Yes	No
Do you have any heart problems?	Yes	No
Do you have high blood pressure?	Yes	No
Do you have varicose veins?	Yes	No
Do you have any history of blood clots?	Yes	No
Have you ever had any cancer?	Yes	No
Do you have arthritis?	Yes	No
Any other medical condition the therapist should be aware of?	Yes	No

Please explain any "yes" answers_____
_____

Do you participate in any sports or exercise program regularly?	Yes	No

What and how often?_____

Are you under a doctor's care?	Yes	No

If "yes," please describe_____

Are you taking any medications?	Yes	No

If "yes," please describe_____

Have you had any acute injuries in the past?	Yes	No

If "yes," please describe_____
FEMALE CLIENTS ONLY:

Are you pregnant?	Yes	No

If "yes," how many months?_____

Is your menstrual period due within the next week?	Yes	No

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, and is not of a sexual nature. I understand 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 conditions. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. If I am under 18 years of age, a parent or parental guardian must also sign for approval of my getting massaged.

Signature of client _____Date_____

Signature of parent (if under 18) _____Date_____