



## Client Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Eve/Cell Phone: \_\_\_\_\_

Would you like to be informed of promotions/specials? YES  NO

Date of Birth: \_\_\_\_\_ Whom can we thank for referring you? \_\_\_\_\_

Emergency Contact name and number: \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Recent injuries, surgeries or accidents: \_\_\_\_\_

Have you previously received a therapeutic massage? YES  NO

What is your expectation for today's session?

General Relaxation  Specific Injury \_\_\_\_\_

Sports Specific  Other- (e.g. fibromyalgia, insomnia,

Stretching  high blood pressure, etc)

Are you currently under medical supervision? YES  NO

Treatment of: \_\_\_\_\_

Physician's name and number: \_\_\_\_\_

Are you currently pregnant or nursing? YES  NO

If pregnant, is your pregnancy high risk? YES  NO

What medications are you currently taking? \_\_\_\_\_

How many glasses/ounces of water do you consume daily? \_\_\_\_\_

How many hours a week do you exercise? \_\_\_\_\_

What sport(s) do you regularly participate in? \_\_\_\_\_

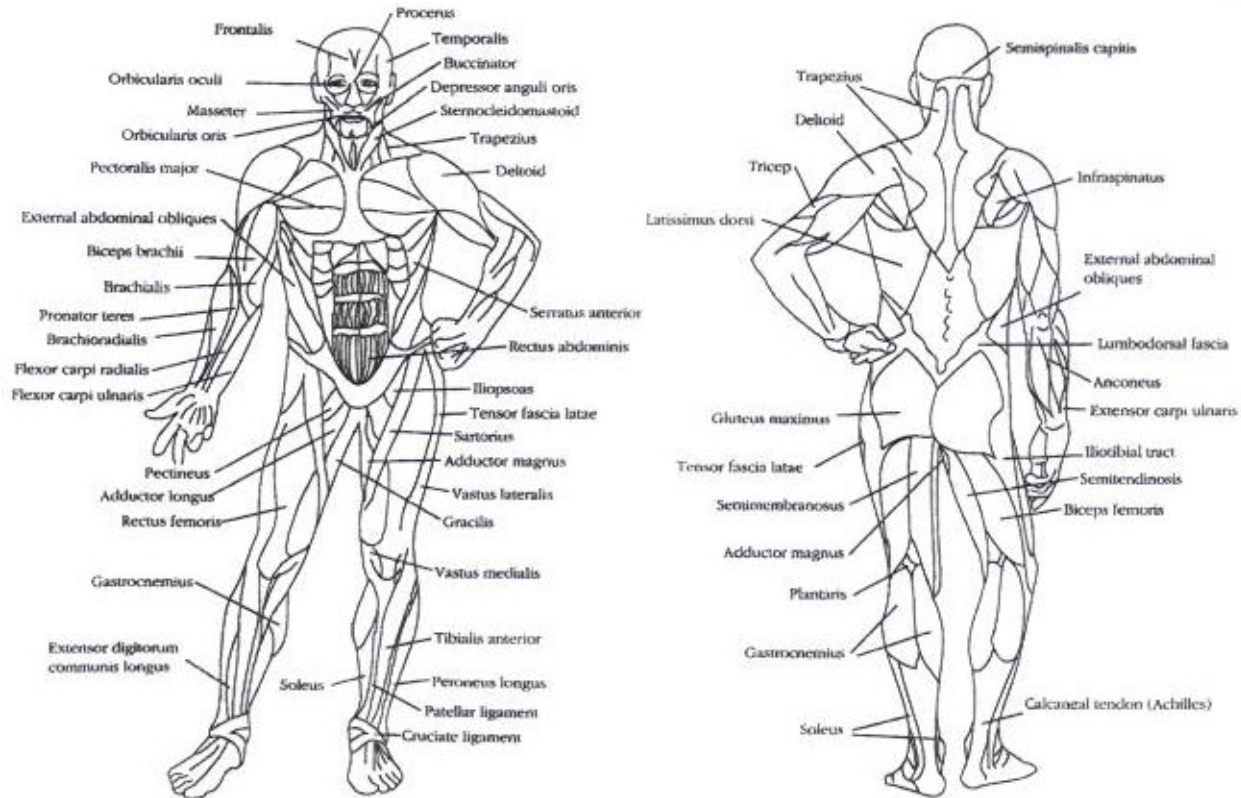
Do you stretch regularly? YES  NO

**Please check if you have or recently (past 5 yrs) have had any of the following:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> aneurysm/blood clots      | <input type="checkbox"/> diabetes             | <input type="checkbox"/> seizures                |
| <input type="checkbox"/> arthritis                 | <input type="checkbox"/> easy bruising        | <input type="checkbox"/> skin infection/rash     |
| <input type="checkbox"/> asthma                    | <input type="checkbox"/> edema/ swelling      | <input type="checkbox"/> stroke                  |
| <input type="checkbox"/> back/neck pain            | <input type="checkbox"/> headaches/migraines  | <input type="checkbox"/> tendonitis/spasm        |
| <input type="checkbox"/> bone/joint condition/pain | <input type="checkbox"/> heart attack/disease | <input type="checkbox"/> tingling in extremities |
| <input type="checkbox"/> cancer/malignancies       | <input type="checkbox"/> hepatitis            | <input type="checkbox"/> torn cartilage/ligament |
| <input type="checkbox"/> chest pain/tightness      | <input type="checkbox"/> ↑/↓ blood pressure   | <input type="checkbox"/> tuberculosis            |
| <input type="checkbox"/> clinical depression       | <input type="checkbox"/> scoliosis/curvatures | <input type="checkbox"/> varicose veins          |

Other: \_\_\_\_\_

**Please indicate problem areas on the diagrams below:**



All information and our sessions are treated with confidentiality. Please give feedback at any time during or after the session. This communication between you and the therapist can lead to a more productive outcome.

I, the client, understand that the work done during my sessions does not constitute medical treatment and that the massage therapist is not a physician. The session is a form of health and wellness maintenance utilizing the techniques of massage and bodywork. I take responsibility for alerting the therapist to any conditions, which may affect this work. It is recommended that I see a physician for any ailments I may have.

**My signature below indicates that I understand and agree to the above conditions.**

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