

Client Information Form

Name:		Date of Birth:	
City:		State:	Zip Code:
Street Address:		E-mail Address:	
Home Telephone :		Cell No:	Work No:
Name of Physician:			
Medications (please list):			
Occupation :			
Primary Reason for Appointment:			
Referred by:			
Please answer following questions by circling Yes or No as applicable, giving further details where appropriate.			
Have you had a professional massage before?			Yes No
Have you had major surgery in last 2 years?			Yes No
Do you have any spinal problems?			Yes No
Do you have any allergies?			Yes No
Do you have any medical or cosmetic implants (including birth control)?			Yes No
Do you wear contacts or dentures?			Yes No
Do you have frequent headaches?			Yes No
Do you have chronic back pain?			Yes No
Do you have any cardiac (heart) problems?			Yes No
Do you suffer from any of the following: High Blood Pressure?			Yes No
Varicose veins			Yes No
Blood clots			Yes No
Diabetes			Yes No
Arthritis			Yes No
Have you ever been diagnosed with cancer?			Yes No
Have you ever had pain that radiates or spreads up and down arms and legs?			Yes No
Do you have chronic diarrhea?			Yes No
Do you have chronic constipation?			Yes No
Do you have any medical condition that I should be made aware of?			Yes No
Do you have any areas I should avoid?			Yes No
Do you have any areas that need more attention?			Yes No
I understand that the decision to seek massage is entirely my own, and massage cannot be viewed as a substitute for proper medical attention. If I am dissatisfied or uncomfortable with any part of the massage I will tell the therapist to correct the problem or end the session. I will remove only as much clothing as I want. I will ask for what I need to make myself comfortable. I have read, and understand, "The Client Decides". I am in charge of my massage.			
Client Signature:		Date:	