

# CLIENT INFORMATION FORM

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Referred By \_\_\_\_\_

.....  
Primary Reason for Appointment:  
\_\_\_\_\_

Have you ever had a professional massage before? \_\_\_\_\_ If yes when? \_\_\_\_\_

.....  
Are you pregnant? Yes \_\_\_ No \_\_\_ if yes, what trimester are you in? \_\_\_\_\_

Have you ever had surgery? Yes \_\_\_ No \_\_\_ if yes, please explain: \_\_\_\_\_

Do you take prescribed medications? Yes \_\_\_ No \_\_\_ if yes, please describe: \_\_\_\_\_

Do you have any spinal problems? Yes \_\_\_ No \_\_\_ if yes, please describe: \_\_\_\_\_

Have you ever suffered any acute injuries? Yes \_\_\_ No \_\_\_ if yes, please describe: \_\_\_\_\_

Do you exercise regularly or participate in any sports? Yes \_\_\_ No \_\_\_ if yes, please describe: \_\_\_\_\_

Do you have any other medical condition that I should be aware of before giving you a massage? Yes \_\_\_

No \_\_\_ if yes, please describe: \_\_\_\_\_

Do you:

Wear contact lenses or dentures? Yes \_\_\_ No \_\_\_ Have any skin problems or allergies? Yes \_\_\_ No \_\_\_

Have varicose Veins or blood clots? Yes \_\_\_ No \_\_\_ Have Arthritis? Yes \_\_\_ No \_\_\_

Have any heart problems? Yes \_\_\_ No \_\_\_ Have blood pressure problems? Yes \_\_\_ No \_\_\_  
.....

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

I understand that the massage therapist does not diagnose illness, disease or any other physical or medical disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does she perform 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 it is recommended that I see a physician for any ailment that I may 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 \_\_\_\_\_