Confidential Client Information

Name _____ Date_____

Address_____ City_____ State Zip _____

Phone_____(h) _____(c) Date of birth_____ E-mail _____

Employer_____ Occupation_____

Emergency contact_____Phone_____

Referred by_____Reason for visit _____

If you have ever received a professional massage:

Date of last massage_____Type of massage _____

What results are you expecting from massage therapy?

_____

_____

_____

Are there any areas you would not like to have focus on? _____

_____

Your body may react to relaxation. It is normal to experience sighing, yawning, changes in breathing, stomach gurgling, emotional feelings, movement of intestinal gas, energy shifts, falling asleep, and memories.

List any physical activities you are involved in and the frequency you participate in them. _____

_____

Please state any past or present injuries, accidents or medical treatments:

_____

_____

Please mark any of the following conditions you have had recently or in the past:

Allergies
Arthritis/Gout
Asthma/Breathing Issues
Back Pain
Blood Clots
Bone/Joint Disease
Cancer
Carpal Tunnel
Chronic Fatigue
Chronic Pain
Cold/Flu/Fever
Depression
Diabetes
Emphysema
Fibromyalgia
Grief Process
Headaches/Migraines
Heart Ailment
High Blood Pressure
Kidney/Bladder Ailment
IBS
Infectious Disease
Liver Ailment
Low Blood Pressure
Lupus
Lymphadema
Neck/Spine Injury
Numbness/Tingling
Open Cuts
Osteoporosis
PMS Syndrome
Phlebitis/Varicose Veins
Pinched Nerve
Pregnancy
Prostrate Problems
Sciatica/Leg Pain

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Scoliosis
Seizures
Severe Pain
Shingles
Sinus Problems
Skin Conditions
Sleep Disorders
Sports Injuries
Surgery
TMJ Syndrome
Tendonitis/Bursitis
Thrombosis/Embolism
Thyroid Dysfunction
Ulcers
Wear Contacts
Wear Dentures
Whiplash
Other

Please include any further details or other information you would like to share here:

_____

_____

If you are currently under the care of a physician:

Physician's name _____

Please list reason(s) _____

_____

Please list any medication taken now or at regular intervals:

_____

_____

The above information is true and accurate to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential. I agree to update my therapist on any changes that occur with my physical or mental health. I understand that massage therapists do not diagnose disease, or any other medical, physical or emotional disorder, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention, examination or diagnosis. If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure or stroke can be adjusted. Therefore, I will not hold my therapist responsible for any pain or discomfort I experience during or after the session. I understand that massage therapy is a therapeutic health aid and any sexual remarks or advances will terminate the session, and I will be liable for payment of the scheduled session. It is my choice to receive massage therapy, and I give consent to receive treatment.

Signature _____ Date_____