Client Information

In order to maximize the effectiveness and safety of your Massage sessions with your therapist, please take the time to carefully fill this out. This information will be treated confidentially. Your feedback is appreciated.

Name _____ D.O.B. _____ Referred by _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Home phone _____ Work phone _____
Have you had a professional massage before? _____Yes _____No
Marital Status _____ # of Children _____ Spouse's Name _____
Check any of the following that may presently apply: Stress _____ Pain _____ Stiffness _____
Self Help _____ Relaxation _____ Personal Growth _____ Other _____
Please state any recent or past injuries or medical treatments: _____
_____

Please check any of the following conditions that apply or have applied:

_____arthritis	_____ear ringing	_____high blood pressure
_____bursitis	_____fainting spells	_____shortness of breath
_____cancer	_____loss of balance	_____menstrual pain/PMS
_____diabetes	_____broken bones	_____skin disorders
_____edema	_____stomach disorders	_____severe irritability
_____diarrhea	_____abdominal hernia	_____severe depression
_____constipation	_____blood clots	_____herniated disc
_____headaches	_____varicose-veins	_____low blood pressure
_____sinusitis	_____heart condition	_____chest pain
_____back pain	_____cold feet/hands	_____numbness feet/hands
_____neck pain		

Do you wear contacts ( ), dentures ( ). hearing aid ( )?

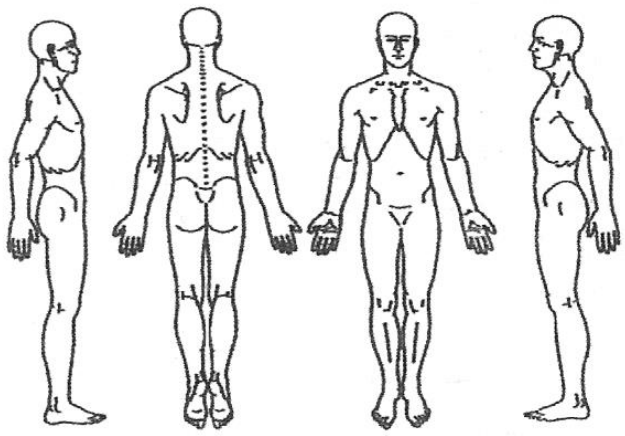
Do you experience difficulty lying on your front ( ), back ( ), and or side ( )?

Are you under medical care or supervision now? Yes No If yes, for what?_____
_____

Are you currently taking any medication? Yes No If yes, what?_____
_____

Physician_____ Phone #_____

PLEASE INDICATE LOCATION(S) OF SORE OR PAINFUL AREAS ON THE DIAGRAM BELOW:



Signature:_____ Date_____