The purpose of this client form is to inform the massage therapist about your physical condition in order to optimize your treatment. All the information collected will be kept strictly confidential. Enjoy your treatment!

Surname:_______________________________ First name: _______________________________

Address:_______________________________ Postal code:_______________________________

Telephone:_____________________________ Cellphone: _______________________________

Email:_________________________________ Date of birth: D D / M M / Y Y....

Tell me about yourself ...

What is your occupation?

____

What sports and leisure activities do you do?

____

Have you ever had a massage before? ☐ Yes ☐ No

How much pressure do you like? ☐ Light ☐ Medium ☐ Firm

Tell me about your health ...

How is your sleep? ☐ Restorative ☐ Deep ☐ Light ☐ Restless

Do you have any allergies? Specify: ____

Do you have any intolerance to smells? If so, to what smell(s)?

____

Have you had surgery or a serious injury in the last six weeks? In the last 6 months? Specify:

____

____

Do you take medication? If so, what for?

____

____

Please check any of the conditions listed below that apply to you:

Musculoskeletal system:

☐ Osteoarthritis	☐ Tendinitis	☐ Bursitis	☐ Fracture
☐ Arthritis	☐ Hernia	☐ Osteoporosis	☐ Other:

Specify: ______________________________

Circulatory system:

☐ Hypertension	☐ Hemophilia	☐ Heart disease	☐ Varicose veins
☐ Hypotension	☐ Phlebitis	☐ Diabetes	☐ Other:

Specify: ______________________________

Digestive system:

☐ Constipation	☐ Diarrhea	☐ Ulcer	☐ Gastric reflux
☐ Crohn's disease	☐ Hepatitis	☐ Other:	

Specify: ______________________________

Nervous system:

☐ Headache	☐ Stress	☐ Anxiety	☐ Depression
☐ Parkinson's disease	☐ Epilepsy	☐ Other:	

Specify: ______________________________

Respiratory system:

☐ Asthma	☐ Bronchitis	☐ Flu	☐ Emphysema
☐ Cold	☐ Other:		

Specify: ______________________________

Immune system:

☐ Fever	☐ Hepatitis	☐ Chickenpox	☐ STBBI
☐ Diseases	☐ Other:		

Specify: ______________________________

Integumentary system:

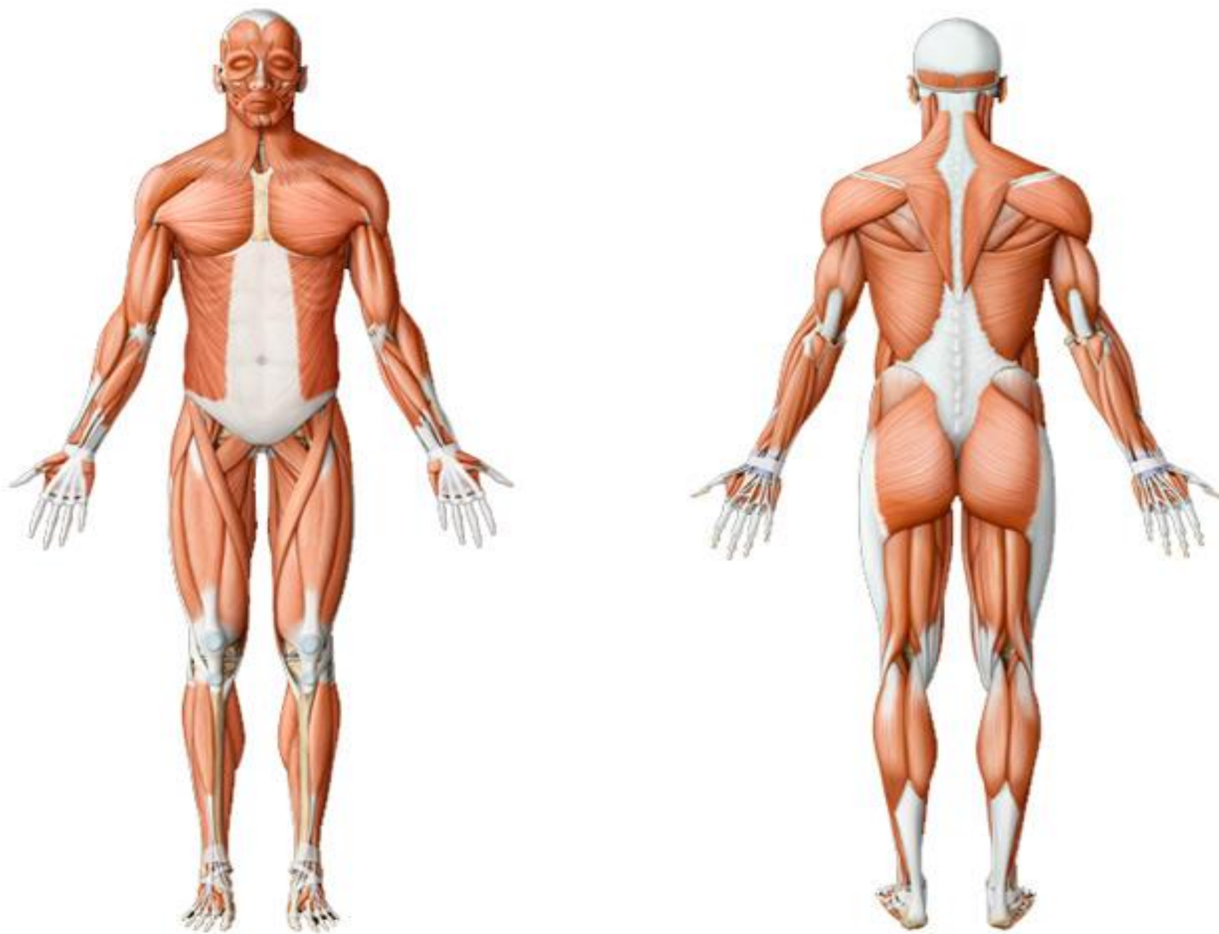
☐ Acne	☐ Eczema	☐ Psoriasis	☐ Hives
☐ Warts	☐ Shingles	☐ Wound:	☐ Other:

Specify: ______________________________

Depending on your health, the nature of the massage treatment may vary or massage therapy may be contraindicated. Please check any of the following situations that apply to you.

- [ ] You are seeing a health professional (e.g., chiropractor, physiotherapist).
- [ ] You are pregnant, menstruating, breastfeeding or in menopause.
- [ ] You have a cancer diagnosis.
- [ ] You have a heart condition.

Please put a box around the areas where you have pain and circle the areas that you enjoy having massaged the most.



Please indicate any health problems that were not listed above.

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Mutual respect policy

To maintain a relaxing and trusting environment, respect for the client and the massage therapist is required. Any disrespect or deviation from the professional framework will not be tolerated.

Declaration of liability

I declare that all the information provided in this client form is true and that I have informed my massage therapist of any physical, psychological, emotional and/or mental conditions that might be a contraindication to treatment. I am aware that the massage therapist may not be held liable if the information is incomplete or contains errors.

Thank you. Enjoy your relaxing time!

Client's signature: ______________________________

Date: ______________________________

Massage therapist's signature: ______________________________

Date: ______________________________