CLIENT INFORMATION FORM

PERSONAL INFORMATION

_____

last name *first name* *middle initial* *mr./mrs./ms*

_____

address *city* *state* *zip*

_____

date of birth *occupation* *cell phone* *home phone*

_____

your physician's name *physician's phone*

Please list your daily activities and/or routines *(i.e. lifting, stretching, yoga, meditation, fitness, typing, computer work, etc.)*

_____

_____

HEALTH CONDITIONS

Please check any conditions or areas of discomfort:

◊ AIDS/HIV	◊ CANCER	◊ HANDS/ARMS	◊ NUMBNESS
◊ ALLERGIES	◊ CARDIOVASCULAR	◊ HIPS	◊ RESPIRATORY
◊ ARTHRITIS	◊ CHEST	◊ INSOMNIA	◊ SHOULDERS
◊ ASTHMA	◊ COLITIS	◊ JOINTS	◊ SINUS
◊ BACK PAIN	◊ DIABETES	◊ LEGS/FEET	◊ SKIN
◊ BLOOD PRESSURE ↑ ↓	◊ DIGESTIVE	◊ NECK/HEAD	◊ VARICOSE VEINS

OTHER *(please explain):* _____

LIST ANY SURGERIES OR ACCIDENTS BELOW - PLEASE INCLUDE MONTH AND YEAR

PLEASE LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING

_____

_____

_____

_____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

How much water do you drink a day? _____

How would you describe the overall level of stress in your life? LOW / MEDIUM / HIGH
circle one

TREATMENT QUESTIONS

Have you ever received a professional massage? YES / NO
circle one

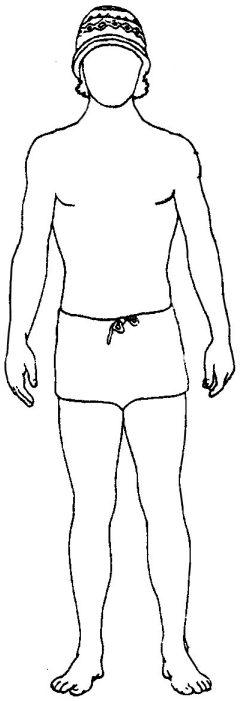
Are you currently taking any blood thinners? YES/NO
circle one

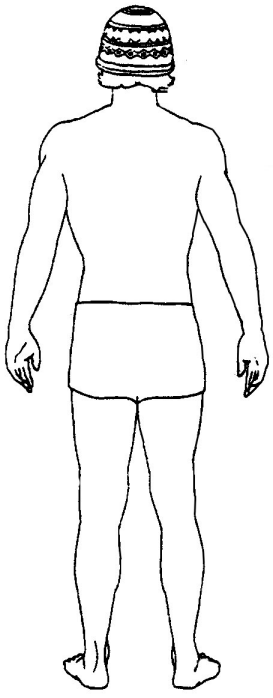
What is your pressure preference? LIGHT / MODERATE / FIRM / DEEP
circle one

Have you ever had any kind of head trauma or a concussion? _____

_____

Please mark an "X" on any areas of discomfort.





DISCLAIMER

I understand that my massage therapist does not diagnose illness, disease, physical or mental disorders. My massage therapist does not prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that this massage is not a substitute for a medical examination or diagnosis.

_____/____/_____
signature *date*