

Massage Client Information Form

Name _____ Birth Date _____

Address _____ Telephone # _____

City _____ ST _____ Zip _____ Business # _____

Occupation _____

How did you learn about me? _____

Have you received Massage Therapy or Bodywork before? _____ How often? _____

What kinds? _____

Was it a positive or negative experience for you? Positive / Negative (circle one)

Please check off any of the following conditions or symptoms which apply to you now or in the past:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Muscle Sprain / Strain
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Heart Attack / Stroke
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin Infections	<input type="checkbox"/> Headaches
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Contagious Conditions	<input type="checkbox"/> Other Conditions

Do you wear contacts? Yes / No (circle one) Do you wear dentures? Yes / No (circle one)

Are you pregnant? Yes / No (circle one) If so, how many months? _____ months

Please list and explain other conditions/symptoms you are or have experienced:

_____ Have you had any serious or chronic illness, operations, or traumatic accidents? Yes / No (circle one)

If yes, please explain: _____

Are you currently, or have you at any time within the last 12 months been under the care of a physician?

Yes / No (circle one) If so, for what condition? _____

Do I have your permission to contact your Doctor? Yes / No (circle one)

Doctor Name: _____ Telephone # _____

Are you on any medication? _____ If yes, which ones? _____

Do you exercise? _____ How many times per week? _____ For how long? _____

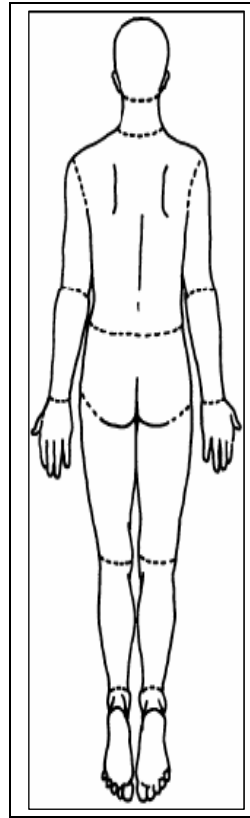
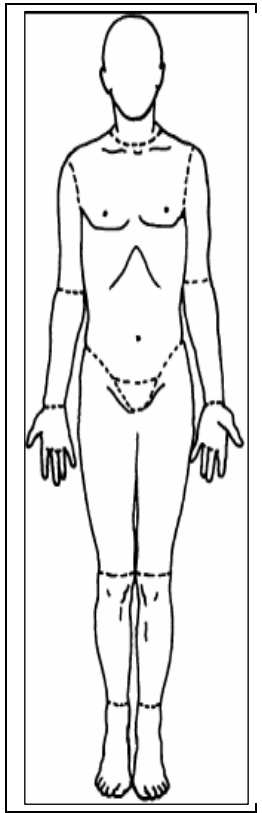
What type of exercise? _____

Is there any other information you feel would be helpful to share with me at this time?

I have completed this health form to the best of my knowledge. I understand that Massage Therapy and Bodywork services are a therapeutic health aid and are non-sexual. They do not take the place of a physician's care when indicated. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services.

Name (signature) _____ Date _____

Please indicate any areas of pain or discomfort you are experiencing.



Area of Pain	No Pain	Mild Pain	Moderate Pain	Severe Pain
_____ L/R	1	2 3 4	5 6 7	8 9 10
_____ L/R	1	2 3 4	5 6 7	8 9 10
_____ L/R	1	2 3 4	5 6 7	8 9 10
_____ L/R	1	2 3 4	5 6 7	8 9 10
_____ L/R	1	2 3 4	5 6 7	8 9 10