

**CLIENT INFORMATION FORM**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Rate your stress level (0=low, 10=high) \_\_\_\_\_

Are you Pregnant? \_\_\_\_\_ How many weeks? \_\_\_\_\_

How often do you receive massage therapy? (circle) never occasionally frequently

\*EMAIL ADDRESS: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

\* Your privacy is of utmost importance. Email addresses are used for Massage Matters appt. reminders & promotions ONLY

**MEDICAL HISTORY - PLEASE CHECK AND DATE ANY THAT APPLY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> high/low blood pressure    | <input type="checkbox"/> allergies/skin sensitivity | <input type="checkbox"/> arthritis, tendonitis |
| <input type="checkbox"/> heart/circulation problems | <input type="checkbox"/> easy bruising              | <input type="checkbox"/> strains, sprains      |
| <input type="checkbox"/> blood clots                | <input type="checkbox"/> abnormal skin condition    | <input type="checkbox"/> fibromyalgia          |
| <input type="checkbox"/> neck/back injuries         | <input type="checkbox"/> varicose veins             | <input type="checkbox"/> diabetes              |
| <input type="checkbox"/> herniated disk             | <input type="checkbox"/> TMJ                        | <input type="checkbox"/> cancer                |
| <input type="checkbox"/> joint injury               | <input type="checkbox"/> headaches                  | <input type="checkbox"/> recent injuries       |
| <input type="checkbox"/> numbness                   | <input type="checkbox"/> dizziness                  | <input type="checkbox"/> major accident        |

Please explain any conditions you have marked above: \_\_\_\_\_

Are you taking any medication that your massage therapist should be aware of and if so, for what condition? \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**DISCLAIMER / AUTHORIZATION STATEMENT**

I understand that a massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, a massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. It has been made very clear to me that this massage therapist is not a substitute for medical examinations and/or diagnosis. Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep this massage therapist updated on my physical health.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_