

PLEASE PRINT

Confidential Massage Client Information Form

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Name _____ Phone - Home _____
 Age _____ Birth date _____ Work _____
 Address _____ Email _____
 City _____ State _____ Zip _____
 Occupation _____ Employer _____

What hobbies, sports or other activities do you participate in? How often? _____

Have you ever received a therapeutic massage before? Yes No If yes, when? _____

Type of massage experienced: Deep Tissue Swedish Other _____

List anything you do NOT like about massage: _____

Primary reason for appointment: _____

What are primary stressors in your life?

Job Family Finances School Relationship Health Posture Other _____

Rate your stress level (circle one): (low) 1 2 3 4 5 6 7 8 9 10 (high)

Who referred you to this clinic? _____

Is a physician, chiropractor, or other health professional currently treating you? Yes No

If yes, for what condition(s)? _____

Are you taking medication? If so, please describe: _____

Are you pregnant? If so, what is your projected due date: _____

Do you have a history of the following?

- accident
- neck pain
- whiplash
- headaches
- disk problems
- mid back pain
- low back pain
- joint ache
- decreased range of motion
- broken bones
- sprains
- seizures
- abdominal pain
- nervous tension
- arthritis, bursitis or gout
- allergies to oils or perfumes
- wear contacts or other prosthesis
- surgery
- fibromyalgia
- breast augmentation
- diabetes
- varicose veins
- high blood pressure
- stroke
- heart attack
- cancer
- colitis
- HIV

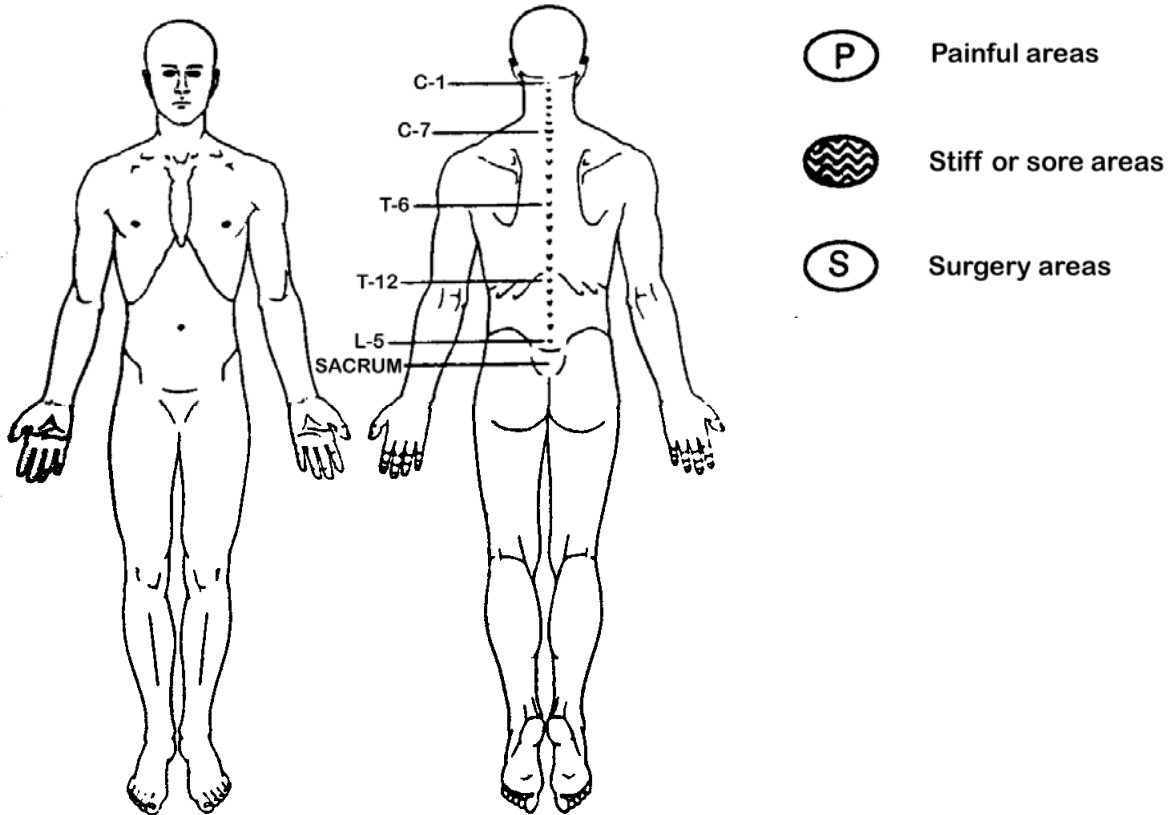
Please indicate if your consumption is:

	None	Light	Moderate	Heavy
Salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other medical condition that I should be aware of? Yes No

If yes, please explain: _____

If you have any of the conditions below, please enter the appropriate code on the body diagram.



Please take a moment to carefully read the following information and sign where indicated.

Waiver of Liability

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, chronic pain, and relief of muscle tension. If I experience any pain or discomfort during any session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment.

I understand that massage therapists/bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such.

Because massage/bodywork should not be administered under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

Please give 24 hours notice if you need to cancel an appointment. If you must cancel in less than 24 hours of your appointment you may be held responsible for the full cost of the massage.

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____