

Client Information Form

Name _____
 Address _____
 City _____ State _____ Zip _____
 Home Telephone _____ Work _____ Cell _____
 Email Address _____
 Occupation _____
 Date of Birth _____ Referred by _____
 Areas of complaint, pain or tension _____

Please answer the following questions by circling the appropriate answer.

- | | | | |
|-----|---|-----|----|
| 1. | Have you ever had a professional massage before? | Yes | No |
| 2. | Do you have skin problems or suffer from allergies? | Yes | No |
| 3. | Do you have arthritis and/or joint disorders? | Yes | No |
| 4. | Do you have varicose veins? | Yes | No |
| 5. | Do you have heart problems? | Yes | No |
| 6. | Do you have spinal problems? | Yes | No |
| 7. | Have you ever had a neck and/or back injury? | Yes | No |
| 8. | Do you have jaw problems, i.e. TMJ syndrome? | Yes | No |
| 9. | Is your lifestyle stressful? | Yes | No |
| 10. | Have you had a significant change in your life recently? | Yes | No |
| 11. | Do you smoke? | Yes | No |
| 12. | (a.) Do you exercise and/or participate in any sports? | Yes | No |
| | (b.) If yes, what kind and how often _____ | | |
| 13. | Are you presently taking any drugs or prescribed medication(s)? | Yes | No |
| 14. | (a.) Do you have any medical condition(s) I should be aware of before performing massage therapy? | Yes | No |
| | (b.) If yes, please specify _____ | | |
| | _____ | | |

By signing this Client Information Form, I hereby acknowledge that Massage Therapy is not a substitute for medical examination or diagnosis. It is recommended that I seek a physician for any physical ailment that I might have. I also understand that the Massage Therapist does not diagnose illness, disease or any other physical or mental disorder. Likewise, the Massage Therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal adjustments.

Signature _____ Date _____