CLIENT INFORMATION FORM

Today's Date _____________

Name: ____ Date of Birth: _____________

Address: ___________________________________ City: ______________________ Zip: _____________

Email: _____________________________________ Referred by: ___________________________________

Preferred contact ph#: H/W/C ________________________ Alternate ph#: H/W/C_________________________

Occupation: ______________________________ Male ___ Female ___ Age ______ Weight ______ Height ______

Activities regularly performed: ____

Reason for visit: Relaxation _______ Pain Relief_______ Increased Flexibility _______ Other ______________________

Stress level (circle one or a range): 1 2 3 4 5 6 7 8 9 10 For how long? _______________________

Have you had massage therapy before? Yes _____ No _____ If yes, where and how many? ______________________

Preferred level of pressure: Mild _______ Moderate _______ Firm _______

Are you allergic to anything? ____

List any medications you are taking and the reasons you are taking them:

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Do you have any of the following today (day of visit)?

- ☐ Sunburn
- ☐ Pregnant
- ☐ Headache
- ☐ Severe pain
- ☐ Cancer
- ☐ Open cuts, bruises, burns
- ☐ Irritated skin, rash, poison ivy/oak
- ☐ Athlete's foot
- ☐ Alcoholic beverage
- ☐ Uncontrolled high/low blood pressure
- ☐ Insulin or other injection (list site) _____ __________________

Have you had any of the following in the last 6 mos?

Surgery Area: ______________________
Date:_______________

Whiplash Area: ______________________
Date:_______________

Broken bones or severe strain, sprain, or tear
Area: ______________________ Date: _______

Do you have a history of any of the following?

HEAD
- ☐ TMJ
- ☐ Grind teeth or clench jaw
- ☐ Headaches/Migraines
- ☐ Head feels heavy
- ☐ Ringing in ears
- ☐ Loss of balance or dizziness
- ☐ Memory loss

NECK
- ☐ Stiff
- ☐ Pain with movement
- ☐ Grinding/Popping

SHOULDERS
- ☐ Can't raise arms above head
- ☐ Other __________________

ARMS/HANDS
- ☐ Hands cold
- ☐ Loss of grip strength
- ☐ Shoot pain
- ☐ Elbow pain/stiffness

ABDOMEN
- ☐ Nausea
- ☐ Gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Tenderness

BACK (circle all that apply)

Low Back/ Middle Back/ Upper Back

Pain is worse when:
- ☐ Lifting
- ☐ Bending
- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Coughing

Other ____________________________

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HIPS/LEGS/FEET
- ☐ Leg/foot cramps
- ☐ Knee pain
- ☐ Cold feet
- ☐ Varicose Veins
- ☐ Shooting pain
- ☐ Other ____________________

GENERAL (Explain or list area as applicable)
- ☐ Allergies
- ☐ Asthma
- ☐ Bursitis
- ☐ Bruise easily
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Sinus
- ☐ Sciatica
- ☐ Shortness of Breath
- ☐ Cardiac/Circulatory condition
- ☐ Seizures/Epilepsy
- ☐ Smoker How much _____________
- ☐ Autoimmune disease
  ______ ______________________
- ☐ Skin condition __________________
- ☐ Inflammation__________________
- ☐ Strain/sprain/tear/break
  ____
- ☐ Arthritis ___________________________
- ☐ Osteoporosis__________________________
- ☐ Numbness/Tingling______________________
- ☐ Diabetes Insulin Dependent? Y N
  Injection site _____________________
- ☐ Infectious disease ______________________
- ☐ Other ____________________________
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If there is anything else the therapist may need to know, please list it here:

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Please read the following statements and initial each acknowledging your understanding.

___________ I understand that the massage/bodywork I receive from the massage therapist is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. 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 or condition for which I am aware. I also understand that the massage therapist does not 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 is contraindicated (should not be performed) under certain medical or other conditions, I affirm that I have answered all questions on this form and/or asked by my therapist, honestly and completely to the best of my knowledge. A referral from my primary care provider may be required prior to service being provided, if I have specific medical conditions or symptoms where massage/bodywork is contraindicated.

___________ I agree to keep my therapist updated in future sessions as to any changes in my medical profile. I also agree to let my therapist know when I have had any alcohol prior to an appointment or if I have taken any medicine, including over the counter medications such as pain relievers, anti-inflammatories, sinus decongestants, etc. , that is not already listed on my intake form. I agree that there is no liability on the massage therapist's part should I fail to do so.

__________ If I experience any pain or discomfort during this and all sessions, I will immediately inform the therapist so that their pressure, strokes, and/or technique may be adjusted to my comfort level.

___________ It is also understood that this is a legitimate, professional service and that any illicit or sexually aggressive or suggestive behavior either physical or verbal made by me will result in immediate termination of the session, and I will be liable for payment for the full scheduled appointment and that I may be reported to the appropriate authorities.

___________ If I miss a scheduled appointment or cancel with less than 24 hours notice, I understand that I will owe a no show/late cancellation fee equal to 50% of the fee for the scheduled service, which must be paid prior to my next massage.

___________ In the event that payment is not made at the time of service for any reason and, therefore, credit is extended, I agree to pay in full by the agreed upon date or be responsible for all costs of collection efforts, including attorney's fees and costs, and interest as allowed by law.

____ ____________________

Client Signature Date