CONFIDENTIAL CLIENT INFORMATION

First Name: _____ M.I._____ Last Name:_____

Address: _____ City:_____State: _____ Zip: _____

Phone(h):_____ (w) _____Date of Birth: _____

Employer: _____ Occupation: _____

Referred :_____e-mail:_____

Reason for Visit: _____

Is this your first professional massage? o Yes o No If no, how frequently do you get a massage?_____

Please state **any recent** injuries, surgeries, accidents or medical treatments:

_____

_____

_____

Please ***circle*** any of the following conditions you have currently. ***Check*** any conditions you've had in the past.

___ Neck/Spine Injury	___ High Blood Pressure	___ Liver Ailment
___ Back Pain	___ Low Blood Pressure	___ Kidney Ailment
___ Sciatica/Leg Pain	___ Skin Disorders	___ Heart Ailment
___ Carpal Tunnel	___ Infectious Disease	___ Fibromyalgia
___ TMJ Syndrome	___ Diabetes	___ Cancer
___ Sport Injuries	___ Arthritis	___ PMS Syndrome
___ Headache	___ Cold/Flu/Fever	___ Grief Process
___ Varicose Veins	___ Pregnancy	Other _____

Are you currently under the care of a physician? _____If "Yes" whom? _____

Please list reason(s): _____

_____

Please list any medications taken now or at regular intervals: _____

_____

_____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I, also, understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature:_____ Date:_____