Client Information

Please fill out this form completely. The better we communicate, the better we can care for you.

Name:____________________________________ Date of Birth: ________________________________

Home Telephone:__________________________ Work Telephone:_______________________________

Address:_________________________________ Cell Phone:___________________________________

City:_________________________ State:______ E-mail:_______________________________________

Zip Code:______________ Occupation:_________________________________

Referred By:_____________________________ In Case of Emergency:__________________________

General & Medical Information

Have you had a serious or chronic illness, operations, chronic virus infections or traumatic accident?___________

Are you in recovery for addictions or abuse?____

Are you under a doctor's, chiropractor's or other health practitioner's care?___________________________

Are you on any medications? If so, what are they?____

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Do I have your permission to contact your doctor/therapist?_____________________________________

Names of doctors, chiropractors, or health practitioners:

Name:____________________________________ Name:____________________________________

Address:__________________________________ Address:__________________________________

Telephone:________________________________ Telephone:________________________________

Why did you come for our services? (relaxation, pain, therapy) *please circle those that apply*

What results would you like to achieve with our work?____

Have you ever experienced a professional massage/bodywork session?________ When?__________________

Section A

Y N Do you frequently suffer from stress?

Y N Do you experience frequent headaches?

Y N Do you have high blood pressure?

Y N Do you suffer from depression?

Y N Do you bruise easily?

Y N Have you ever had surgery?

Y N Do you suffer from back pain?

Y N Have you had any broken bones, accidents Or suffered any injuries in the past two years?

Y N Do you have an infectious disease?

Y N Do you have tension or soreness?

Y N Do you have numbness or stabbing pains anywhere?

Y N Are you sensitive to touch/pressure?

Y N Do you have any other medical conditions I should be aware of?

Section B

Y N Are you epileptic?

Y N Are you pregnant?

Y N Are you diabetic?

Y N Do you have arthritis?

Y N Are you wearing contact lenses?

Y N Do you have cardiac or circulatory problems?

If you answered "yes" to any of the questions in Section A, please explain as clearly as possible.

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I Understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to keep my therapist informed of any changes in my physical condition which may affect treatment. I understand that I will be charged in full for missed appointments and cancellations without 24 hr. Notice, unless my appointment time is filled.

Clients Signature____ Date____________________________