

Client Information Massage

Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Telephone: _____ Work: _____
Birth Date: _____ Emergency Contact: _____
Occupation: _____ Relationship: _____
Hobby: _____ Telephone: _____

Have you ever received a professional massage? _____ If so when? _____

What do you like most about a massage? _____

What areas of your body would you prefer to receive NO massage? _____ Face _____ Head
_____ Buttocks _____ Abdomen _____ Chest _____ Bottom of Feet _____ Other _____

What area of your body would you prefer to focus on? _____

What is your general health? _____

If you are in physical pain or discomfort today, please describe it. _____

If you have had and serious illness, accident injury or surgeries, please describe.

Are you currently under a physicians care, chiropractic care or other professional health care? If yes please explain.

Please indicate if you have any of the following health conditions:

| | | |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rash | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Typhoid | <input type="checkbox"/> Herpes/Shingles | <input type="checkbox"/> Breathing Difficulty |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Edema(Swelling) | Other _____ |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Pregnant <input type="checkbox"/> Stage | |
| <input type="checkbox"/> Severe Respiratory Infection | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood Clots | |

Current medications including aspirin: _____

Please list any allergies: _____

I give my consent to receive massage therapy. I understand that massage therapy is designed to enhance good health, and is not intended to replace a doctor's care when necessary. Any information exchanged during the course of a massage therapy session is for educational purposes to be used at my own discretion. I further understand that massage therapists do not diagnose physical or mental disorders; neither do they prescribe medical or psychiatric treatment. I have provided the above information to the best of my knowledge and will inform the massage therapist of any changes in my health status. If under the age of 18, parent or legal guardian signature required.

Signature _____ Date: _____