

Client Information Form

DATE: _____

NAME: _____ D.O.B: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE NUMBER: _____ EVENING PHONE NUMBER: _____

OCCUPATION: _____ EMPLOYER: _____

REFERRED BY: _____

HAVE YOU HAD A MASSAGE BEFORE: _____ IF YES, HOW MANY: _____

PRIMARY REASON FOR APPOINTMENT: _____

ARE YOU LOOKING FOR (CIRCLE ALL THAT APPLIES):

RELAXATION • INCREASED FLEXABILITY • PAIN RELIEF • INCREASE RANGE OF MOTION

DO YOU PREFER LIGHT, MEDIUM, OR DEEP PRESSURE? _____

EMERGENCY CONTACT- NAME, NUMBER & RELATION: _____

PLEASE INDICATE IF YOU CURRENTLY HAVE (X) OR PREVIOUSLY HAVE HAD (P) ANY OF THE LISTED CONDITIONS:

- | | | |
|---|--|--|
| <input type="checkbox"/> HEADACHES / MIGRAINES | <input type="checkbox"/> CHRONIC PAIN | <input type="checkbox"/> ALLERGIES OR TENDONITIS |
| <input type="checkbox"/> HEARING PROBLEMS / DEAFNESS | <input type="checkbox"/> MUSCLE/JOINT INJURIES OR PAIN | <input type="checkbox"/> RASHES / ATHLETES FOOT |
| <input type="checkbox"/> INJURIES TO FACE OR HEAD | <input type="checkbox"/> TENSION OR STRESS | <input type="checkbox"/> INFECTIOUS DISEASE |
| <input type="checkbox"/> SINUS PROBLEMS | <input type="checkbox"/> NUMBNESS OR TINGLING | <input type="checkbox"/> BLOOD CLOTS |
| <input type="checkbox"/> DENTAL BRIDGES / BRACES | <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> VARICOSE / SPIDER VEINS |
| <input type="checkbox"/> JAW PAIN / TMJ PROBLEMS | <input type="checkbox"/> SPRAINS OR STRAINS | <input type="checkbox"/> HIGH / LOW BLOOD PRESSURE |
| <input type="checkbox"/> ASTHMA OR LUNG CONDITIONS | <input type="checkbox"/> ARTHRITIS OR TENDONITIS | <input type="checkbox"/> FATIGUE |
| <input type="checkbox"/> HEART / CIRCULATORY PROBLEMS | <input type="checkbox"/> CANCER / TUMORS | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> SPINAL COLUMN DISORDERS | <input type="checkbox"/> PREGNANCY |
| | | <input type="checkbox"/> FIBROMYALGIA |

EXPLAIN ALL MARKED CONDITIONS: _____

CURRENT MEDICATION INCLUDING ASPIRIN, IBUPROFEN, HERBS, SUPPLEMENTS, ECT: _____

SURGERIES: _____

HOBBIES: _____