CONFIDENTIAL CLIENT INFORMATION FORM

Name: _____ Date Of Birth:_____ GENDER: **M F**

Address: _____ City:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Occupation: _____ E-Mail Address: _____

In case of emergency, notify : _____ Phone: _____

Check any of the following you have <u>today</u>:

☐ Cold/Flu ☐ Fever ☐ Headache ☐ Poison Ivy ☐ Sunburn ☐ Irritated skin rash

☐ Open cuts ☐ Bruises ☐ Severe Pain ☐ Burns ☐ Inflammation

Indicate your consumption of the following:

Salt ____ Sugar ____ Caffeine ____ Tobacco ____ Alcohol ____ Water ____ Exercise ____

0 = None, 1 = Light, 2 = Moderate, 3 = Heavy

Any serious injury, illness or surgery (including the spine or joints) ? _____

Are you in recovery for any addictions or abuse? YES ☐ NO ☐

Are you currently under the care of a Doctor, Chiropractor, or Physical Therapist? YES ☐ NO ☐

If so, for what condition? _____

Are you taking any medication? YES ☐ NO ☐ If so, for what? _____

Do I have permission to contact your Doctor or Therapist if necessary? YES ☐ NO ☐
If yes, please provide that contact information:

Name:_____ Name:_____

Phone: _____ Phone: _____

Have you received massage therapy before? YES ☐ NO ☐ Did you find it helpful? YES ☐ NO ☐

How was your experience? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ BAD ☐ VARIED

You came today for: Therapy, Pain Relief, Relaxation, Other: _____

Please indicate any area(s) you want me to focus on today: _____

Check all that apply:

___ Back Pain
___ Neck Pain
___ Disc Problems
___ Joint aches/pains
___ Arthritis/Bursitis/Gout
___ Decreased Range of Motion
___ Headaches
___ Stress
___ High blood pressure
___ Varicose Veins
___ Diabetes
___ Cancer
___ Allergies to oils or perfumes
___ Seizures
___ Stroke, When? _____
___ Heart attack. When?_____
___ Abdominal Pain
___ IBS / Colitis
___ Orthotics
___ Whiplash
___ Pregnant
___ Recent broken bones
___ HIV / Hepatitis
___ Sprains

Symptom	Location	For how long?	How Often	Additional Comments
Pain				
Soreness				
Muscle Spasm				
Numbness/Tingling				
Burning				
Other				

I have completed this information to the best of my knowledge. I understand the massage services are designed to be a health aid and are in no way to take the place of a doctors care when indicated. Information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my discretion.

Date: _____ Signature: _____