

# CLIENT INFORMATION

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_  
In case of emergency: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

## GENERAL & MEDICAL INFORMATION

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female Physician: \_\_\_\_\_

Yes  No Have you ever experienced a professional massage or bodywork session? How recently? \_\_\_\_\_

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

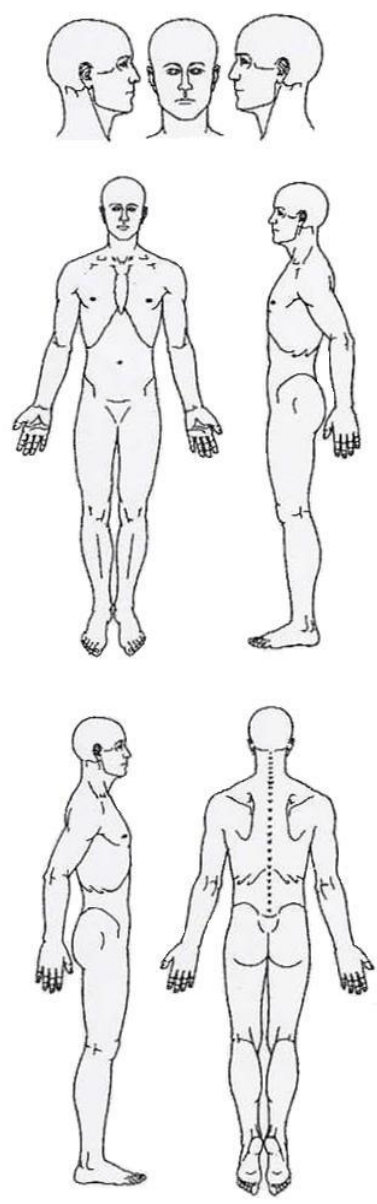
- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you frequently suffer from stress?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have diabetes?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you experience frequent headaches?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you pregnant?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you suffer from arthritis?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you wearing contact lenses?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you wearing dentures?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have high blood pressure?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | If "yes" to previous question, are you on medication?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you suffer from epilepsy or seizures?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you suffer from joint swelling?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have varicose veins?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had surgery?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any contagious diseases?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have osteoporosis?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any allergies?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you bruise easily?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you had any broken bones in the past two years?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you been in an accident or suffered any injuries in the past two years?                      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have tension or soreness in a specific area?<br>Please specify: _____                      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have cardiac or circulatory problems?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you suffer from back pain?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have numbness or stabbing pins anywhere?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you very sensitive to touch or pressure in any area?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you had surgery in the past five years? Explain below  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any other medical condition or are you taking<br>Any medications I should know about? |

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please take a moment to carefully read the following information and sign where indicated. If you have a specific Medical condition or specific symptoms, massage bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive for the basic purpose of relaxation and relief from muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spiral or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

**Draw your symptoms**  
Indicate or draw your pain pattern or symptoms if any.



The diagram area contains several line drawings of the human body for symptom tracking: three views of the head (profile, front, and back), a full-body front view, a full-body side view, a side view of the head and neck, and a back view of the torso and spine.

Clients Signature \_\_\_\_\_ Date \_\_\_\_\_

Practitioners Signature \_\_\_\_\_ Date \_\_\_\_\_