

CLIENT INFORMATION FORM

Name _____ Address _____

City _____ State _____ Zip _____

Phone _____ Contact number _____

Date of Birth _____ Physician _____

Occupation _____

Referred by _____

Hobbies (Do you relax and have fun???) _____

Previous Experience with Massage _____

Tense or sore areas needing attention _____

Please mark (X) next to all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> exercise regularly | <input type="checkbox"/> chronic pain | <input type="checkbox"/> allergies, sensitivity |
| <input type="checkbox"/> participate in sports | <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> pregnancy | <input type="checkbox"/> arthritis | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> contact lenses | <input type="checkbox"/> cancer, tumors | <input type="checkbox"/> rash, athletes foot |
| <input type="checkbox"/> dentures | <input type="checkbox"/> spinal column disorders | <input type="checkbox"/> infectious disease |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> medications |
| <input type="checkbox"/> jaw pain, TMJ problems | <input type="checkbox"/> heart problems | <input type="checkbox"/> surgery |
| <input type="checkbox"/> asthma, lung conditions | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> recent acute injury |
| <input type="checkbox"/> constipation, diarrhea | <input type="checkbox"/> tension, stress | <input type="checkbox"/> other medical conditions |

Explain any areas noted above _____

I understand that bodywork is for the purpose of relaxation and stress reduction. I further understand that the facilitator does not diagnose illness, disease or other physical or mental disorder. As such, the facilitator does not prescribe medical treatment or perform spinal manipulations. It has been made clear that bodywork is not a substitute for medical treatment. Because a facilitator must be aware of existing physical conditions, I have stated all known medical conditions and take it upon myself to keep the facilitator updated on my physical health.

Signature _____ Date _____