

CLIENT INFORMATION All information will be kept confidential.

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

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

E-mail: _____ Occupation: _____

Date of Birth: _____ Sex: M F Contact Lenses? Yes No # of massages in past? _____ How did you hear about us? _____

Why do you want a massage? _____

Have you ever been in an auto accident? Y/N (Describe if yes): _____

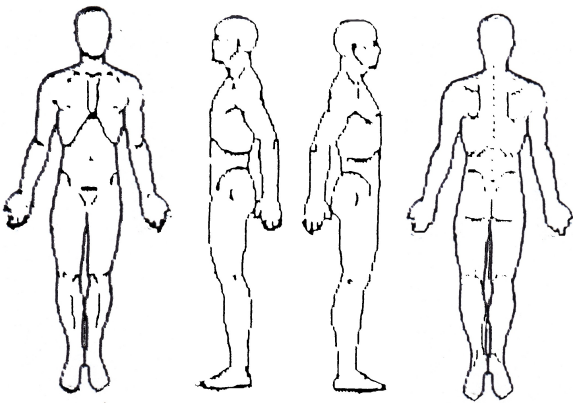
List all medications you currently take: _____

Who is your health care provider/MD? _____ Phone: _____

Describe any surgeries, broken bones, major injuries or accidents below – include dates: (use back if necessary): _____

Please check if you have had problems with any of the following

Other conditions or information

<input type="checkbox"/> Sinus/allergies	HIPS, LEGS, FEET	ARMS, HANDS	_____
<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Leg or foot cramps	<input type="checkbox"/> Hands cold	_____
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Feet feel cold	<input type="checkbox"/> Loss of grip strength	_____
<input type="checkbox"/> Skin condition/rash	<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Shooting pains	_____
Where _____	<input type="checkbox"/> Bunions		_____
<input type="checkbox"/> Infectious condition	<input type="checkbox"/> Shooting pains	LOW BACK	_____
Where _____	<input type="checkbox"/> Hip replacement	Pain is worse when:	_____
<input type="checkbox"/> Area of inflammation	<input type="checkbox"/> Knee surgery	<input type="checkbox"/> Lifting	_____
Where _____		<input type="checkbox"/> Sitting	_____
<input type="checkbox"/> High/low blood pressure	SHOULDERS	<input type="checkbox"/> Lying down	_____
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Can't raise arm	<input type="checkbox"/> Bending	_____
<input type="checkbox"/> Seizures/convulsions	<input type="checkbox"/> Above shoulder	<input type="checkbox"/> Coughing	Please circle any areas of pain or injury.
<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Over head	<input type="checkbox"/> Working	
<input type="checkbox"/> Varicose veins			
<input type="checkbox"/> Bruise easily	HEAD	ABDOMEN	
<input type="checkbox"/> Heart condition	<input type="checkbox"/> TMJ	<input type="checkbox"/> Nausea	
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Grind teeth	<input type="checkbox"/> Gas	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Splint	<input type="checkbox"/> Constipation	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Shortness of breath	Where _____	<input type="checkbox"/> Tenderness	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Head feels heavy		
	<input type="checkbox"/> Loss of memory	FEMALES	
NECK	<input type="checkbox"/> Lights bother eyes	<input type="checkbox"/> Pregnant	
<input type="checkbox"/> Pain with movement	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> # of months	
<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Menstrual pain	
<input type="checkbox"/> Grinding/popping	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Irregular cycle	

PLEASE READ BACK AND SIGN

PLEASE READ BEFORE SIGNING

I understand that the massage I receive is provided for the basic purposes of relaxation and relief of muscular tension. If I experience any pain or discomfort during my sessions, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my comfort level. I further understand that massage 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 ailment that I am aware of. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the massage should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have listed 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. If I have a specific medical condition or specific symptoms, massage may be contraindicated and a referral from my doctor may be required prior to service being provided. I understand that this clinic has a 24-hour cancellation policy and I will be liable for full payment for any appointments canceled after this time.

Client Signature: _____ Date: _____