CLIENT INFORMATION FORM FOR MASSAGE CLINIC

NAME: ________________________ BIRTH DATE: __________ SEX: __F __M

ADDRESS: ____

CITY: ____________________ STATE: __________ ZIP: __________

PHONE #(HOME): ( ) __________ PHONE # (WORK): ( ) __________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

General Health Condition ________________________________

Have you had any serious or chronic illness, operations, chronic virus infections, or traumatic accidents? ____________________

Are you in recovery for addictions or abuse? _____YES _____ NO

Are you under: doctor's, chiropractor's, or other health practitioner's care?
___YES ___NO If Yes, for what condition(s)? ____________________

and what doctor: ____________________ phone # ____________________

Are you on any medication? ___YES ___NO If Yes, what? ____________________

Do you currently have or do you have a history of?

*	a) Diabetes	yes_____	no_____
*	b) High blood pressure	yes_____	no_____
	c) Arthritis	yes_____	no_____
	d) Severe varicose veins	yes_____	no_____
*	e) Heart problems	yes_____	no_____

For your safety, as well as ours, anything that is questionable may result in refusal of a service until a medical doctor is seen and a doctor's note is rendered. *High blood pressure, heart problems and diabetes requires a doctors note due to the health situation and liability. (no matter the severity).

Why did you come for our services? __relaxation __pain __therapy __other

What results would you like to achieve with our work? ____________________

Have you had any massage therapy before? __YES __NO If Yes, by whom? __________

How did you find out about our services? ____________________

In case of emergency notify: Name____________________ Phone__________

I have completed this information form 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 doctor's care when it is indicated.

______________________________ Date

____
Client Signature Date

Please check all that apply to you:

	Acne		Insomnia
	Allergies		Lupus
	Arthritis		Metal Plates or Pins
	Asthma		Pacemaker
	Cancer		Phlebitis
	Chronic Fatigue		Plastic Surgery
	Contact Lens		Pregnant
	Cuts, Wounds, Stitches		Psoriasis
	Depression		Rashes
	Eczema		Scleroderma
	Epilepsy		Seborrhea
	Fibromyalgia		Sensitivities
	Hepatitis		Shingles
	HIV		Surgery
	Hyper/Hypothyroid		Thrombosis

Please list any other diagnosis not listed here ______________________________

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I verify that I have noted all areas applicable to me and I agree to notify my therapist of any changes, if any, at my next visit.

Printed Name ______________________________

Signature ______________________________ Date ______________