MASSAGE THERAPY
Client Information Form

The following information is confidential and will not be released without your written consent.

GENERAL INFORMATION

Name: _____ Date:_____
Address:_____ Postal Code:_____
Home phone:_____ Business phone:_____
Date of Birth:_____ Occupation:_____

AHC#:_____ Referred By:_____
Insurance Plan:_____
Doctor Name:_____
Chiropractor Name:_____
Date of last massage:_____ Email: _____

CLINICAL DATA

Height:_____ **Weight:**_____
Present injury problem:_____
Started when?_____
What action recreates pain?_____
What eases the pain?_____
Does the pain radiate?_____
Past Injuries: What?_____ When?_____
Where?_____
Any stiffness/pain as result of?_____
Medications: Name of drug:_____ Dosage/Day:_____
Reason for taking:_____
Surgeries:_____

Check if any apply (Past / Present):

Cancer__ Diabetes__ Heart Disease__
Epilepsy__ Bursitis__ Whiplash__
HIV__ Osteoporosis__ Asthma__
Arthritis__ Digestive Problems__ Blood Clots__
Low blood pressure__ Stroke__ Paralysis__
High blood pressure__ Varicose Veins__ TMJ disorder__
Kidney problems__ Scoliosis __
List all allergies:_____

Check any that you experience once / twice per week:

Headache___
Faintness/dizziness___
Tightness of jaw___
Weakness in parts of body___
pain___
Numbness and / or tingling___
Grinding of teeth___

Soreness in muscles___
Indigestion___
Cold hands and feet___
Nervousness___

Poor appetite___
Heavy feeling of limbs___

Constipation___
Fatigue___
Insomnia___
Lower back

Allergies___
Neck pain___

For women: are you pregnant? Y___ N___

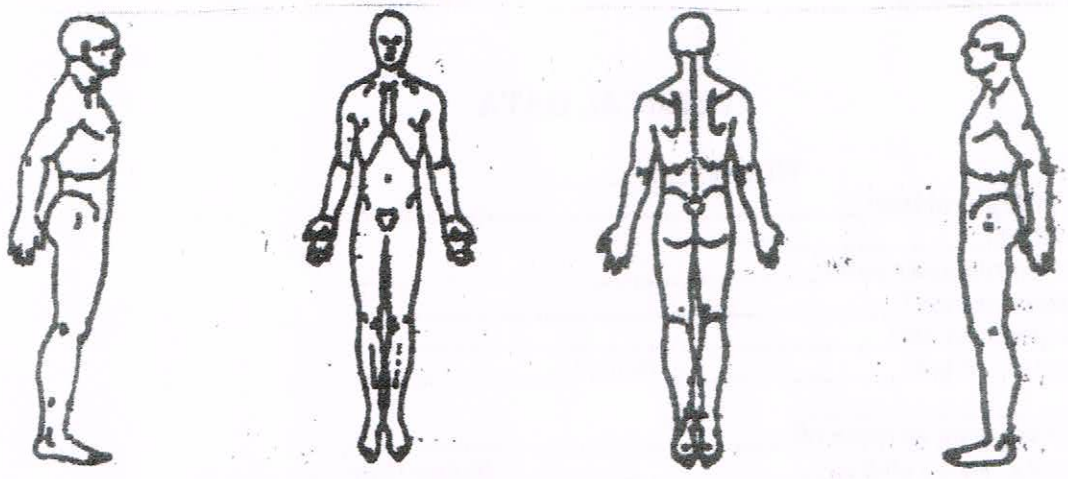
Habits: Do you exercise? ___ What type of exercise:_____ How often:_____

Do you drink water? ___ How much per day?____

How well do you sleep? _____ Do you Smoke?_____

What would you rate your stress level at: 1 2 3 4 5 6 7 8 9 10.

Outline where are you experiencing pain?



I understand and accept that massage is given here for the purpose of stress reduction: for the relief from muscular tension, spasm or pain for increasing circulation.
I understand and accept that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. The massage therapist will not prescribe medical or pharmaceutical treatment, nor do they perform spinal manipulations. It has been made clear to me and I understand that massage is not a substitute for medical examination or diagnosis and it is recommended that I see a physician for any physical ailments I may have. I have informed the massage therapist of all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health and any changes to it. I declare the information provided to be true and correct in all respects. I release the massage therapist from any and all claims whatsoever that arise out of any treatment that he or she provides to me.

Client signature:_____ Date:_____