

### Massage Client Information

Today's Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender: M \_\_\_ F \_\_\_ Referred By: \_\_\_\_\_

Are you presently treated by: MD? \_\_\_ Chiro? \_\_\_ PT? \_\_\_ Acup? \_\_\_ Other \_\_\_\_\_

Physician: \_\_\_\_\_ Location: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

In Case of Emergency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

List all current medical conditions, broken bones, serious illnesses, hospitalizations, and surgeries

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List all prescriptions, medications or nutrition supplements you are taking (include dosage, frequency, herbs and over the counter).

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**Check all that apply:**

- Back Pain – ( ) Lower ( ) Middle ( ) Upper ( ) Food Allergies ( ) Constipation ( ) Arthritis  
( ) Skin Allergies ( ) Diarrhea ( ) Cancer ( ) Nausea  
( ) Chronic Fatigue ( ) Stomach Pain ( ) Headaches ( ) Ulcers  
( ) Depression / Anxiety ( ) Gout ( ) Diabetes ( ) Joint Swelling ( ) Heart Disease  
( ) Joint Replacement ( ) Cold (current) ( ) Nerve Pain ( ) Multiple Sclerosis ( ) Numbness  
( ) Fever ( ) Chest Pain ( ) Difficulty Breathing ( ) Bruise Easily ( ) Chronic Cough  
( ) Tuberculosis ( ) Eczema / Psoriasis ( ) Open Wounds ( ) Varicose Veins  
( ) Asthma ( ) High Blood Pressure ( ) Low Blood Pressure

( ) Are you pregnant? Y / N

**Comments / Additional Information:**

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**I understand that the massage therapy I receive is for the purpose of stress reduction, relief from muscular tension or spasm, or for improving circulation. I further understand that a massage therapist is not qualified to diagnose illness, disease, or any other medical disorder and does not perform high velocity joint manipulations. I understand that massage therapy is contraindicated for some medical conditions and failure to disclose such conditions could result in injury or increase symptoms for which the therapist will not be held liable. I am responsible for consulting a qualified physician for any ailment that I may have. 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 forget to do so.**

**CANCELLATIONS:**

**I understand the appointment policies and agree to adhere to the terms as required.**

**Client Signature** \_\_\_\_\_