Client Information Form

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please indicate time of day you can be reached at each number:

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email Address: _____

Date of Birth: _____

Occupation: _____

Employer: _____

How did you hear about us?

- ☐ Referral - Referred by: _____
- ☐ Yellow Pages ☐ Newspaper ☐ Radio - Which Station: _____
- ☐ Flyer ☐ Billboard ☐ Other: _____

In case of emergency, please contact:

Name: _____ Phone: _____

Relationship: _____

Massage Background

Number of massages received: _____ Date of last massage: _____

Reason for seeking massage therapy: _____

_____

What are your expectations of this massage? _____

_____

Client Health History

Name: _____

Check the following conditions that apply to you, past and present. Please add comments to clarify the condition.

- ☐ Headaches
- ☐ Joint stiffness / swelling
- ☐ Spasms / cramps
- ☐ Broken / fractured bones
- ☐ Back, hip pain
- ☐ Shoulder / neck / arm / hand pain
- ☐ Leg / foot pain
- ☐ Jaw pain / TMJ disorder
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Spinal Deformity
- ☐ Sinus Problems
- ☐ Asthma

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen ankles / Edema
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots / blood thinner use
- ☐ DVT
- ☐ Cardiac / circulatory problems
- ☐ Allergies
- ☐ Stroke / TIA
- ☐ History of Cancer
  - What type: _____
  - Treatment: _____
  - Lymph Nodes removed: _____ # _____

- ☐ Rashes
- ☐ Athlete's foot
- ☐ Warts
- ☐ Moles

- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas / bloating
- ☐ Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Colitis

- ☐ Numbness / tingling
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Chronic Fatigue Syndrome

- ☐ Pregnant
- ☐ PMS
- ☐ Menopause
- ☐ Fertility concerns

- ☐ Depression
- ☐ Hearing Impairment
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Whiplash
- ☐ Other _____

- ☐ Difficulty concentrating
- ☐ Alcohol use _____
- ☐ Caffeine use _____
- ☐ Frequent stress

Please list any accidents or operations with date and description: _____

_____

List any medications (including aspirin) and the reason you are taking them: _____

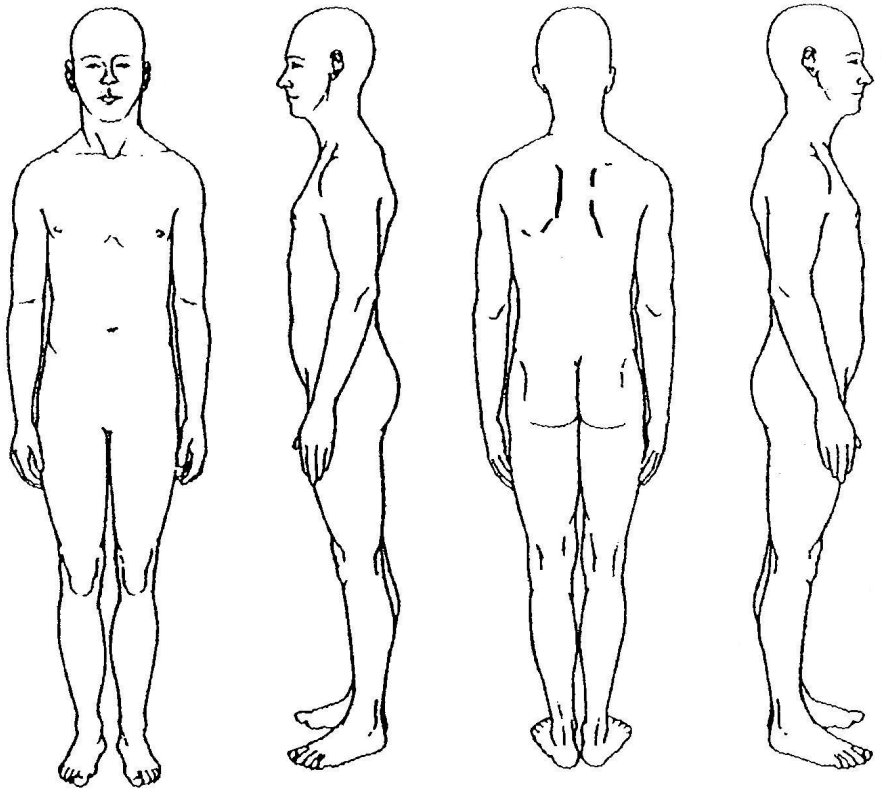
_____

Please list any nutritional supplements you are taking: _____

_____

Please identify current problem areas in your body by making the appropriate marks on the figures below.

XXXXXX – areas where pain exists



Additional Comments: _____

_____

_____

If you have a specific medical condition or symptom, massage therapy may be contraindicated. The student or professional therapists of Charter Health Center may require a referral from your primary care provider before service is provided.

I understand that the bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. Thus, the bodywork I receive shall not be considered a substitute for medical examination, diagnosis or treatment by a qualified physician, chiropractor or other specialist. I understand that massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe or treat any physical or mental illness and nothing said in the course of the session will be construed as such. Because certain physical conditions may contraindicate massage, I certify that the health information I have provided is accurate and I agree to update the Center of any changes in this condition. I understand that my failure to do so is not the liability of the Center or the practitioner. **I also understand that any illicit or sexually suggestive remarks or advances will terminate the session and payment in full will be expected.**

Signature: _____ Date: _____

I hereby give consent for _____ , a minor, to receive massage services.

Signature of Parent or Guardian: _____ Date: _____