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Confidential Client Information

Name _____	Home/Cell Phone _____
Address _____	Work Phone _____
City/State/Zip _____	E-mail _____
Birthdate _____	Employer _____
Emergency Contact Name _____	Occupation _____
Emergency Contact Phone _____	Referred by _____

Please answer the following questions:

yes/no	Have you ever had a professional massage?
yes/no	Do you exercise regularly or participate in sports? <i>If yes, what kind and how often?</i>
yes/no	Do you take any medications (including aspirin or other over-the-counter medications)? <i>If yes, please list.</i>
yes/no	Are you currently under the care of a physician or other health care provider? <i>If yes, please explain.</i>
yes/no	Have you ever had surgery? <i>If yes, please describe surgery and give date for each.</i>
yes/no	Have you ever suffered an acute injury? <i>If yes, please describe injury and give date for each.</i>
yes/no	Do you have varicose veins, blood clots or other circulatory problems? <i>If yes, please describe.</i>
yes/no	Do you have arthritis? <i>If yes, please indicate whether rheumatoid or osteo.</i>
yes/no	Do you have high or low blood pressure? <i>If yes, please indicate which and state your normal BP.</i>
yes/no	Do you have spinal problems? <i>If yes, please describe, including how long you've had the problem.</i>
yes/no	Do you have abdominal pain, digestion problems or constipation? <i>If yes, please describe.</i>
yes/no	Are there areas of your body that need special attention? <i>If yes, please indicate.</i>
yes/no	Are there areas of your body that you prefer not to be worked? <i>If yes, please indicate.</i>

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my massage therapist any time I feel that my well-being is being compromised.

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I acknowledge that both my time and my massage therapist's time are valuable. I agree to give my massage therapist at least 24 hours notice if I have to cancel any appointment. I understand that if I cancel with less than 24 hours notice, I will be charged a fee equal to one-half of the fee for that session. Appointments missed with no call will be charged a fee equal to the fee for that session before my next session.

I have stated all medical conditions of which I am aware and will update my massage therapist of any changes in my health status.

Signature _____ Date _____