



CLIENT RECORD

Please print clearly and complete this entire form. This information is critical to your treatment, as it may affect the structure and focus of your session. All information disclosed will be kept strictly confidential.

Name: _____

Date: _____

Phone: _____

Email Address: _____

Date of birth: _____

Occupation: _____

Address: City ST ZIP _____

What is your main physical activity at work? (check all that apply)

On Phone Computer Work Lifting Sitting

Standing Driving Other (please describe below)

Other: _____

Please describe your exercise habits: _____

Have you ever had therapeutic massage before? _____

Yes No Frequently

Please select any painful or tense areas, as well as regions where you tend to hold your stress:

Frequent headaches Backaches Tense shoulders/Stiff neck

Upset stomach Leg/foot cramps Other (please describe below)

Other: _____

Please describe any recent injuries or medical conditions: _____

Please list any medications that you take: _____

GENERAL MEDICAL SIGNS AND SYMPTOMS			
Please indicate if you currently have any of the following conditions.			
Symptom	Yes	No	Location: Please describe
Any areas of infection?			
Any areas of swelling, edema or abnormal sensation?			
Any areas of numbness or abnormal sensation?			
Any areas of pain or tenderness?			

SPECIFIC MEDICAL CONDITIONS			
For your safety, I must be aware of all medical conditions for which you have been diagnosed. Therapeutic massage may impact these and your health.			
Symptom	Yes	No	Location: Please describe
Arthritis:			
Cancer or Tumors:			
Cardiovascular diseases: (Please check all that apply)	Anemia		Angina
	Arteriosclerosis		Congestive Heart Failure
	Heart Attack		Heart Murmur
	Hemophilia		Hypertension / High blood pressure
	Varicose or Spider Veins		Other (please describe below)
Diabetes:			
Injuries:			
Kidney or Liver Disease:			
Respiratory/Lung conditions:			
Skin conditions: (Please check all that apply)	Acne	Abrasions / Cuts	Bruises
	Dermatitis	Eczema	Herpes
	Hives	Poison ivy/oak/sumac	Psoriasis
	Skin tags	Sunburns	Warts
	Other:		
Other medical conditions:			

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. If I experience any pain during this session, I will immediately inform the practitioner so that the work can be adjusted to my level of comfort. I further understand that massage/bodywork should not be used as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. Because massage can be harmful under certain medical conditions, 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.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the full scheduled appointment. Should I need to cancel future sessions, I agree to give my practitioner 24 hours notice or I will be financially responsible for the session time.

SIGNATURE: _____ DATE: _____