

CLIENT INFORMATION RECORD

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Occupation: _____ DOB: _____

Emergency Name & Number: _____

How did you hear about us? _____

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Please take a moment to carefully read the following information and sign where indicated. If you have specific medical conditions or symptoms, massage /bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? [] YES [] NO How recently? _____

Primary reason for appointment? _____

Do you currently have pain? _____ If yes, circle one on Pain Scale:

No Pain- 0 1 2 3 4 5 6 7 8 9 10= Worst Pain

- | | | |
|--|--|--|
| ___ Yes ___ No Headaches/Migraines | ___ Yes ___ No Tension/Stress | ___ Yes ___ No Fatigue |
| ___ Yes ___ No Chronic Pain | ___ Yes ___ No Joint Pain | ___ Yes ___ No Bone Injuries |
| ___ Yes ___ No Muscle Pain/Injuries | ___ Yes ___ No Rotator Cuff Injury | ___ Yes ___ No Arthritis |
| ___ Yes ___ No Numbness or Tingling | ___ Yes ___ No Trouble Sleeping | ___ Yes ___ No Muscle Sprains, Strains |
| ___ Yes ___ No Bone Breaks/Fractures | ___ Yes ___ No Tendonitis | ___ Yes ___ No Jaw Pain, TMJ |
| ___ Yes ___ No Chronic Sinus Issues | ___ Yes ___ No Allergy/Sensitivity | ___ Yes ___ No Rashes, Athletes Foot |
| ___ Yes ___ No Infectious Disease | ___ Yes ___ No Spinal Column Disorders | ___ Yes ___ No Blood Clots/Phlebitis |
| ___ Yes ___ No Asthma, Lung Conditions | ___ Yes ___ No Circulatory Problems | ___ Yes ___ No Heart Attack |
| ___ Yes ___ No Constipation, Diarrhea | ___ Yes ___ No Digestive Problems/Disorders | ___ Yes ___ No Lupus |
| ___ Yes ___ No Hernia | ___ Yes ___ No High Blood Pressure | ___ Yes ___ No Mental Illness |
| ___ Yes ___ No Heart Conditions | ___ Yes ___ No Fibromyalgia | ___ Yes ___ No Depression |
| ___ Yes ___ No Wearing Contacts | ___ Yes ___ No Wearing Dentures | ___ Yes ___ No Grieving |
| ___ Yes ___ No Bruise Easily | ___ Yes ___ No Osteoporosis | ___ Yes ___ No Whiplash |
| ___ Yes ___ No Pregnant | ___ Yes ___ No Surgeries | ___ Yes ___ No Diabetes Type __1__2 |
| ___ Yes ___ No Epilepsy/Seizure | ___ Yes ___ No Other medical conditions we should be aware of? | |

If you answered "Yes" to any of the above questions, we will discuss them before your massage.

___ Yes ___ No On computer more than 2hrs/day? No. of hours. _____

___ Yes ___ No Chronic Pain? Activities that aggravate the pain: _____

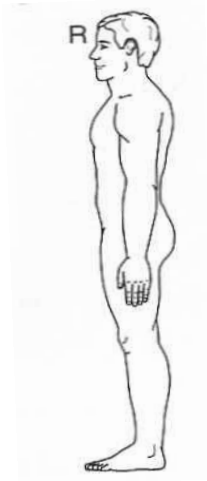
___ Yes ___ No Accident or injury in the last two years? If yes briefly describe: _____

Have you ever had cancer ? [YES] [NO] Type: _____

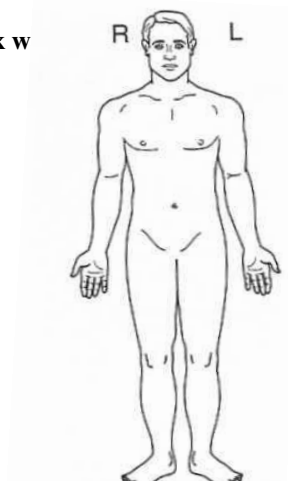
Date diagnosed: _____ Time Recovered: _____ WBC (4.5-10): _____ PLT (150-450): _____

Treatment/s: _____

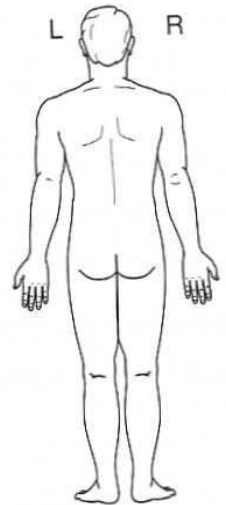
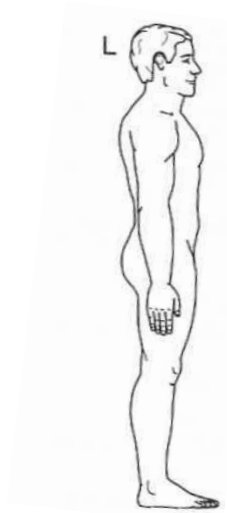
Were any lymph nodes removed/irradiated? [YES] [NO] If yes, Neck [] Armpit [] Groin []



Mark w



soreness or concern of any kind



Explanation: _____

Therapist Notes:

Therapist _____