CLIENT INFORMATION RECORD

Name:
_____ **Date: _____**

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

Phone: _____ Email: _____

Occupation: _____ DOB: _____

Emergency Name & Number: _____

How did you hear about us?_____

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.

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

___Yes___No Chronic Pain? Activities that aggravate the pain:_____

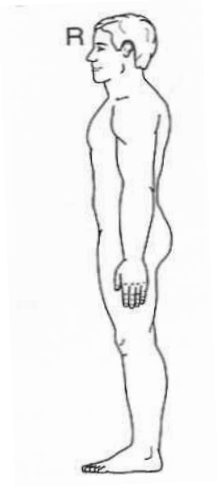
___Yes___No Accident or injury in the last two years? If yes briefly describe:_____

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 [ ]



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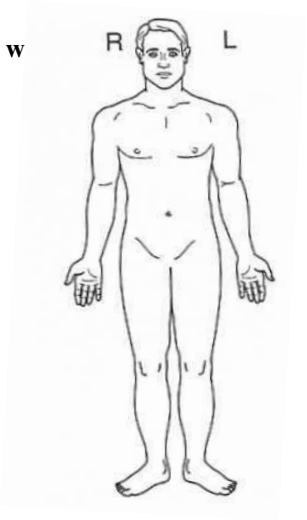
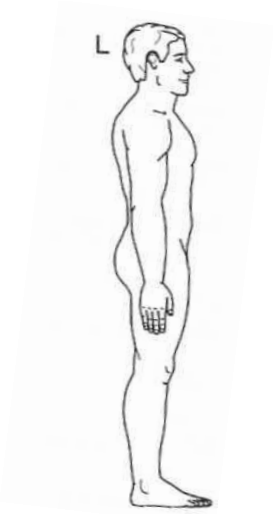
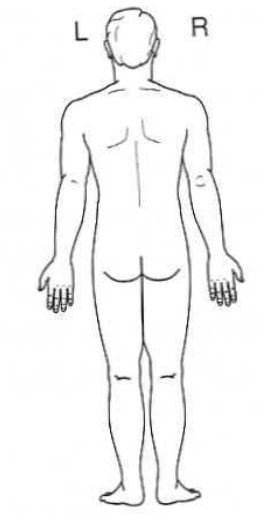


soreness or concern of any kind





Explanation: _____

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Therapist Notes:

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Therapist_____