

**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.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

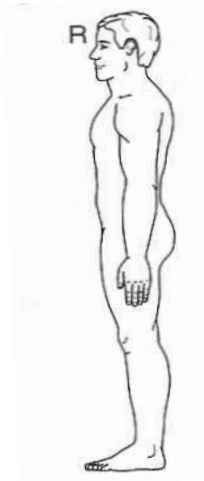
- \_\_\_ Yes \_\_\_ No On computer more than 2hrs/day? No. of hours. \_\_\_\_\_
- \_\_\_ Yes \_\_\_ No Chronic Pain? Activities that aggravate the pain: \_\_\_\_\_
- \_\_\_ Yes \_\_\_ No Accident or injury in the last two years? If yes briefly describe: \_\_\_\_\_

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

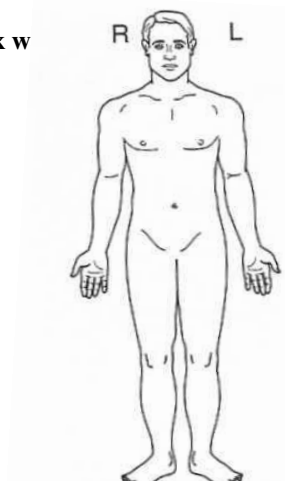
Date diagnosed: \_\_\_\_\_ Time Recovered: \_\_\_\_\_ WBC (4.5-10): \_\_\_\_\_ PLT (150-450): \_\_\_\_\_

Treatment/s: \_\_\_\_\_

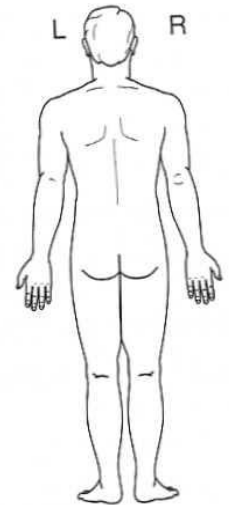
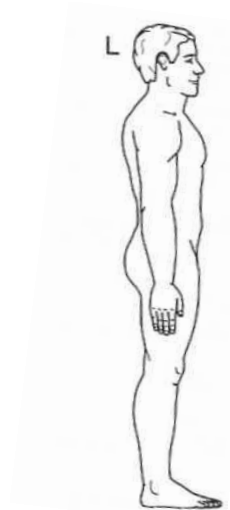
Were any lymph nodes removed/irradiated? [YES] [NO] If yes, Neck [ ] Armpit [ ] Groin [ ]



Mark w



soreness or concern of any kind



Explanation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Therapist Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Therapist \_\_\_\_\_