Client Information Sheet

Date:_____ Client #:_____

Name:_____ Nickname:_____
Address:_____ City:_____ State:_____ Zip:_____

***We send a reminder the morning of your massage. If you would like a text, please provide your cell phone #**

Land Line_____ Cell Phone_____ Work Phone_____
Employer:_____ Occupation:_____ Sex: M F Marital Status: S M D W
Birth date:_____/_____/_____How did you hear about our clinic?_____

Are you taking any medications?	Yes No What kind?_____
Are you pregnant? Yes No	
List Physicians seen within the last year:	For what conditions:
_____	_____
_____	_____

INSURANCE INFORMATION: ***If your insurance covers massage therapy***

Insured's Full Name_____ Soc. Sec. #_____
Address (If different from pt.)_____City_____
State_____ Zip_____ Home Phone_____
Relationship to insured: Self Spouse Child Other_____
Insurance Company_____ Phone #_____
Group #_____ Insured ID #_____ Insured Birth Date:_____
Employed by:_____
Employer's Address:_____City_____State_____Zip_____
Employer's Phone:_____

Please answer all questions below and comment if necessary:

Have you ever had a therapeutic massage before? _____

Have you had:

- o A fall or accident recently
- o A broken bone in the past 2 years
- o Surgery in the past 2 years
- o Pain in arms, shoulders or legs
- o Any spinal problems
- o Physically or sexually assaulted or abused
- o An allergic reaction, particularly to peanuts/nuts?
- o Respiratory problem(s)
- o Cancer

Indicate if you have any of the following conditions:

- o Diabetes
- o A Heart Condition
- o Epilepsy
- o Low Back Pain
- o High Blood Pressure
- o Headaches
- o Chronic bowel problems
- o Arthritis or other joint problems
- o Skin Problems:_____

Do you regularly: o Smoke o Wear Contact Lenses o Drink Alcohol

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that some medical conditions may be worsened by massage therapy, and it is for this reason that the above information was given by me and was offered to enable the therapist to avoid problems arising from contra-indications during the massage session. I agree to keep the therapist updated as to my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

I understand that the massage/bodywork I receive is provided for the purpose of assisting the client in soft tissue relaxation or therapy. If I experience any pain or discomfort during this session I will immediately inform the therapist so that the pressure and strokes maybe adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. And that I should see a Physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists/bodyworkers are not qualified to diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session should be construed as such.

I also understand that any illicit or sexually suggestive remarks or advances made by me, the client, will result in immediate termination of the session. Under these circumstances, I accept the responsibly to pay the session, in full, regardless of duration of the session.

Signed:_____ Date:_____

Therapist:_____ Date:_____