

**MESSAGE CLIENT INFORMATION FORM**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Email: \_\_\_\_\_ Birthday: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

How did you learn about us and/or who referred you? \_\_\_\_\_

Please answer the following questions by marking the appropriate answer.

Are you pregnant?	Yes ___ No ___	Do you have frequent headaches?	Yes ___ No ___
Do you have arthritis?	Yes ___ No ___	Do you have high blood pressure?	Yes ___ No ___
Do you have varicose veins?	Yes ___ No ___	Do you wear contact lens?	Yes ___ No ___
Do you have any blood clots?	Yes ___ No ___	Have you had professional massage?	Yes ___ No ___

Do you have any allergies? Yes \_\_\_ No \_\_\_

\_\_\_\_\_ (If yes, please specify)

When was your last massage? \_\_\_\_\_

Reason for appointment?

\_\_\_\_\_

Explain any physical condition such as back problems, heart condition, cancer, recent surgeries or minor injuries:

\_\_\_\_\_

Medications \_\_\_\_\_ Physician \_\_\_\_\_

I, \_\_\_\_\_ understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, not performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I also understand and agree 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_