Client Information

Name_____ Date of Birth _____ ☐ Male ☐ Female

Address_____City/State/Zip_____

Home Phone_____ Cell Phone_____ Email_____

Occupation_____ Referred By_____

In case of emergency_____ Phone _____

Physician's Name & Phone_____

Have you ever received professional massage/bodywork before? ☐Yes ☐No When? _____

What are your bodywork goals? _____

Please list any surgeries, accidents or major illnesses and dates _____

_____

Please list any medicines or supplements you are currently taking _____

_____

Please circle any applicable conditions and provide dates if not ongoing:

add/adhd _____

allergies _____

arthritis, tendonitis _____

autism/ sensory issues_____

back pain _____

blood clots _____

blood pressure (high/low) _____

cancer, tumors _____

dentures, braces _____

depression, psychiatric _____

digestive _____

diabetes _____

fatigue _____

headaches/head injuries _____

hearing _____

heart, lung condition _____

hormones, thyroid _____

infectious disease _____

jaw pain / tmj _____

lymph nodes removed/ radiation _____

neck pain _____

numbness, tingling _____

osteoporosis _____

pregnancy _____

rashes, athlete's foot _____

seizures (type, frequency) _____

spine, scoliosis _____

sinus problems _____

stroke _____

swelling _____

varicose veins _____

vision/contacts _____

other _____