

CLIENT INFORMATION

Do you have any of the following conditions? (Check all that apply)

How is your health in general? ___ Good ___ Fair ___ Poor

- | | |
|---|--|
| <input type="checkbox"/> Are you wearing contacts | <input type="checkbox"/> Recent high fever |
| <input type="checkbox"/> Are you wearing hearing aids | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High stress | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Recent motor vehicle accident | <input type="checkbox"/> Spinal Condition |
| <input type="checkbox"/> Are you pregnant or new mother | <input type="checkbox"/> Herniated or Degenerative Disc(s) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Recent Surgery | <input type="checkbox"/> Varicose/Spider Veins |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Do you bruise easily | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Circulatory ailments, especially phlebitis or thrombosis | <input type="checkbox"/> Nerve Damage |
| <input type="checkbox"/> Infectious / communicable disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Inflamed or infected injuries | <input type="checkbox"/> Osteoporosis / Osteopenia |
| <input type="checkbox"/> Inflammatory disease such as rheumatoid arthritis | <input type="checkbox"/> Lymphatic or skin cancer |
| <input type="checkbox"/> Areas of hemorrhage or heavy tissue damage | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Skin conditions such as psoriasis | <input type="checkbox"/> Auto-Immune disorder |
| <input type="checkbox"/> Recent fractures or sprains, strains | <input type="checkbox"/> Hepatitis: Type _____ |
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Other _____ |

Are you taking medication? Please list _____

Are you under 18? Parental consent required _____

Where do you store your tension? _____

When was your last massage? _____

What is the nature of your visit today? ___ Relaxation ___ Sport Oriented
___ Therapeutic ___ Other _____

What intensity massage do you prefer? ___ Light ___ Medium ___ Deep

Are you currently being treated by a physician or therapist? ___ Yes ___ No

Have you been referred by a physician or therapist? ___ Yes ___ No

If Yes, Name: _____ Phone: _____

Insurance Provider: _____ Phone: _____

I hereby acknowledge that the above information is true and correct to the best of my knowledge. I authorize any release of records or information from the above referring physician to Massage Therapy, Inc. pertaining to the conditions listed above. Massage Therapy, Inc will hold no liability for any omissions with regard to treatment of the above stated conditions.

Please sign here: _____

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