Client History Form

Name_____ Today's Date_____
Address_____ Phone:_____
City/State/Zip_____ Cell: _____
_____
Date of Birth_____ Email: _____

Occupation_____

In case of emergency, contact : _____
Relationship_____ Phone_____

Primary Health Care Provider:_____ Phone_____
May I have permission to consult your health care provider? NO____ YES _____
Please list any medications currently taking:_____
_____
Please indicate any of the following conditions that apply to you:

__ Chronic pain, where? _____	__Joint pain, where? _____	__Muscle pain, where? _____
__Headache	__Numbness, where? _____	__Sprains/Strains, where? _____
__Arthritis	__Osteoporosis	__Bursitis
__Tendonitis	__Scoliosis	__Sinus conditions
__Swollen Ankles	__Varicose veins	__Hypertension
__Heart conditon	__Constipation	__Anxiety
__Depression	__Trouble sleeping	__Allergies
__Skin conditions	__Paralysis	__Pregnant

I understand that the massage services are designed to be a health aid and are in no way to take the place of a doctors care when indicated. I am aware that the Massage Therapist does not diagnose disease nor prescribe medications. Information exchanged during any massage session is educational in nature and is intended to help me become more aware and conscious of my own health status and is to be used at my own discretion.

Client signature_____Date_____

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