

Confidential Client Information and History Form

First Name:

Middle Int:

Last Name:

Address:

State:

Zip:

Phone: (H):

Cell:

Employer:

Occupation:

Emergency
Contact:

Phone:

Referred By

Email:

Is this your first professional
massage:

if no, when was your last
one?

What do you hope to accomplish from today's massage?

Are you aware of any tension holding spots?

Describe any hospitalization, accidents or injuries you have had.

Less than 5 yrs.

More than 5yrs.

What kind of care did you receive if any?

Do you think you have recovered?

Explain:

Do you have any chronic, ongoing pain that you deal with on a daily bases?

If so, explain:

Describe any activities that cause this pain or make it worse:

If so, explain

Are you receiving any type of medical treatment?

If so, explain:

Please list any medication (vitamins, herb or pharmaceutical) you are taking now.

If so, explain

Are you under the care of a physician:

If so, who & reason:

Are there any other health concerns you would like to discuss today?