MASSAGE THERAPY CLIENT INFORMATION FORM

Name _____ Address _____

City, State _____ Zip Code _____ E-mail address _____

Cell Phone_____ Home/business phone_____

Birthdate _____ Occupation _____

Leisure Activities _____

General Health _____ Blood Pressure _____

Serious or Chronic Illness, Operations, Traumatic Accidents or Chronic Viral Infections? _____

_____

Are you under a Doctor, Chiropractor or Health Practitioner's Care? _____

If so for what condition? _____

Are you on Medication? _____ If so, what? _____

Do I have permission to contact your doctor(s)? _____

Please list their name(s)/number(s) _____

What made you seek out massage? (relaxation, etc.) _____

Have you had any massage therapy before? _____ If so, by whom? _____

Who referred you? _____

In case of emergency notify: Name _____ Phone _____

I have completed the information above to the best of my knowledge. I understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care when it is indicated. I understand that the information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

Our time together is precious and I agree to cancel with a minimum of 24 hours in advance. Unless there is an emergency, if I miss an appointment, I agree to pay 1/2 the appointment fee. After that, any non-emergency appointments missed without cancellation notice, I agree to pay the full fee. Thank you for honoring my policy.

Date _____ Signature _____