

**Massage Therapy Center  
Client Health Form**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_ Physician \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Primary reason for this visit is \_\_\_\_\_

**Please answer the following as they apply to you (Circle where indicated)**

Have you had a professional massage before? Yes No

Do you exercise regularly or participate in any sports? Yes No

If yes, what kind and how often? \_\_\_\_\_

Do you wear contact lenses? Yes No

If yes, what type? Soft \_\_\_\_\_ Hard \_\_\_\_\_

Do you wear dentures? Yes No

Do you have any skin problems? Yes No

If yes, please describe \_\_\_\_\_

Do you have any allergies? Yes No

If yes, please describe \_\_\_\_\_

Have you suffered an acute injury in the past year?

If yes, please describe \_\_\_\_\_

Do you take any prescribed medication? Yes No

If yes, please describe \_\_\_\_\_

Do you have any spinal problems? Yes No

If yes, please describe \_\_\_\_\_

If you are pregnant, in which trimester are you? \_\_\_\_\_

Do any of the following apply to you? (circle any which apply)

Varicose Veins      Arthritis      Blood Clots      Heart Problems

High Blood Pressure      Low Blood Pressure      Cancer      AIDS

Do you have any tense or sore areas that require special attention? Yes No

If yes, please describe \_\_\_\_\_

Do you have any medical conditions that we should be aware of before giving you massage therapy? Yes No

If yes, please describe \_\_\_\_\_

I, \_\_\_\_\_, understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow.

I understand that massage therapists do not diagnose illnesses, disease or any other physical or mental disorder. As such, the massage therapist(s) do not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis, and that it is recommended that I see a physician for any physical ailment that I may have. Because the massage therapist must be aware of existing physical conditions, I have stated all of my known medical conditions and take it upon myself to keep the massage therapist(s) updated on my physical health.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist \_\_\_\_\_ Date \_\_\_\_\_

# Massage Therapy Center Client Information Form

All client information is strictly confidential and will never be released to a third party without your written consent.

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ First Appt. Date \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Mobile Phone or Pager ( ) \_\_\_\_\_ E-mail \_\_\_\_\_

How did you learn about the Massage Therapy Center?

Received Gift Certificate \_\_\_\_ Yellow Pages \_\_\_\_ Friend \_\_\_\_ Relative \_\_\_\_

BXI \_\_\_\_ Malibu Exchange \_\_\_\_ Radio \_\_\_\_ Promotion Exchange \_\_\_\_

Banner on side of building \_\_\_\_\_ Sign in window \_\_\_\_\_

Internet (please circle how you found our site):

Yahoo Google City Search MSN AOL Alta Vista

Lycos Excite HotBot Dogpile Digital City

Superpages.com Smartpages.com Other Yellow Pages

Other \_\_\_\_\_

Name of person who referred you if applicable \_\_\_\_\_