

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 _____