# Confidential Client Information Form

Date: _____

Name: _____

Address _____ Apt: _____

City:_____ State: _____Zip: _____

Phone (Cell #):_____ (Home #):_____Email: _____

Date of Birth:_____

Occupation: _____

In case of Emergency: _____ Phone: _____

What are your main concerns, area of pain or discomfort?

_____

What is your goal for this treatment?

_____

Please list any allergies to powder, oil (including essential oils) or fragrances?

_____

Are you taking any medications and /or herbs? Y/N_____

Please list: _____

Medical History: To the best of your knowledge, if you had or presently have any of the following conditions, please mark "C" for a current condition or "P" for a past condition.

| **Condition: C or P** | **Condition: C or P** | **Condition: C or P** |
|---|---|---|
| Allergies: _____ | Arthritis/ Joint Pain _____ | Asthma _____ |
| Back Pain/ Injury_____ | Blood Pressure/ High_____ | Blood Pressure/ Low_____ |
| Bursitis/Acute _____ | Claustrophobia_____ | Cancer_____ |
| Cardiovascular Disease _____ | Chronic Infection _____ | Cold hands and feet_____ |
| Dizziness _____ | Diabetes _____ | Digestive_____ |
| Epilepsy_____ | Fatigue _____ | Fibromyalgia_____ |
| Fibrosis _____ | Head or Neck Trauma _____ | Headaches_____ |

| **Condition: C or P** | **Condition: C or P** | **Condition: C or P** |
|---|---|---|
| Hemophilia _____ | Hepatitis _____ | HIV _____ |
| Kidney Disease _____ | Lymphedema/Lipedema_____ | Numbness/Stabbing Pains_____ |
| Menstrual Cramps _____ | Muscle Pain _____ | Neck Pain _____ |
| Pregnancy _____ | Skin: Rashes /Acne _____ | Sciatica _____ |
| Feet/Ankles: Sour/Swollen _____ | Spinal Disc Injury _____ | Stroke _____ |
| TMJ / Jaw Pain _____ | Thrombosis _____ | Varicose Veins _____ |
| Warts / Athlete's Foot / Fungus_____ | Congested Heart Failure_____ | Other _____ |

Have you ever had a major accident, injury or surgery (please indicate if re nerve or lymphatic system damage was concerned?)

And if so how, when, and where? _____

What worked? _____

What did not? _____

Do you: Smoke? _____ Drink? _____ Exercise? _____

Please list any additional comments regarding your health and well-being.

_____

I understand the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I should immediately inform the therapist so the pressure and /or stokes may be adjusted to my level of comfort. Further, I understand that bruising can occur due to varying tissue and health conditions. I understand that bruising is more prevalent in longer/deeper therapies and certain areas of the body may also be more sensitive than others. I understand the goal is no bruising or discomfort and that communication is the key.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental, emotional or physical ailment that I am aware of. I understand massage/bodywork therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical, emotional or mental illness, and nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known conditions and answered all questions honestly since some therapies could actually aggravate certain conditions. I agree to keep my massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the part of the therapist should I neglect to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. **Furthermore, I understand any missed appointments or cancellation without 48 hours' notice will result in payment in full for the missed appointment.**

Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____