CLIENT INFORMATION FORM

NAME_____
LAST FIRST MIDDLE

ADDRESS_____

CITY_____STATE_____ZIP_____

TELEPHONE_____
HOME WORK CELL

E-MAIL ADDRESS_____

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE? Yes_____No_____

DATE OF BIRTH_____ SEX M_____ F_____

PRIMARY REASON FOR MASSAGE_____

WHAT TYPE OF SESSION DO YOU PREFER? CONVERSATION OR QUIET

HOW DID YOU FIND OUT ABOUT US?_____

WHAT IS YOUR OCCUPATION?_____

DO YOU EXERCISE OR REGULARLY PARTICIPATE IN SPORTS? Y____N___
IF YES, DESCRIBE THE ACTIVITIES AND FREQUENCY_____

_____

LIST ANY HOBBIES OR REGULAR ACTIVITIES_____

DO YOU EAT A BALANCED DIET? YES_____ NO_____

RATE YOUR NORMAL STRESS LEVEL 1(Low) TO 10 (High)_____

RATE YOUR GENERAL CONSUMPTION OF THE FOLLOWING

	Heavy	Moderate	Light	None
ALCOHOL	Δ	Δ	Δ	Δ
CAFFEINE	Δ	Δ	Δ	Δ
TOBACCO	Δ	Δ	Δ	Δ
SUGAR	Δ	Δ	Δ	Δ

PHYSICIAN'S NAME_____PHONE_____
DATE OF LAST EXAM_____

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? Yes_____ No_____
IF YES, PLEASE DESCRIBE_____

_____

OVER PLEASE

HAVE YOU BEEN HOSPITALIZED IN THE LAST YEAR? Yes_____ No_____
IF YES, PLEASE DESCRIBE_____

DO YOU WEAR CONTACT LENSES_____ DENTURES_____ PROSTHESIS_____

ARE YOU PREGNANT? Yes_____ No_____ IF YES, DUE DATE_____

RATE YOUR GENERAL HEALTH: Excellent____ Good____ Fair_____ Poor_____

LIST YOUR PRIMARY AREAS OF DISCOMFORT OR TENSION_____

PLEASE CHECK ANY CONDITIONS YOU HAVE:

- ☐ ALLERGIES
- ☐ CARPAL TUNNEL SYN
- ☐ DIABETES
- ☐ JOINT PROBLEMS
- ☐ RESPIRATORY PROBLM
- ☐ SPINAL PROBLEMS
- ☐ ARTHRITIS
- ☐ CIRCULATORY PROBLEM
- ☐ HEART DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ SKELETAL INJURIES
- ☐ VARICOSE VEINS
- ☐ BLOOD CLOTS
- ☐ CONTAGIOUS DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ MUSCULAR INJURIES
- ☐ SKIN PROBLEMS
- ☐ OTHER

PLEASE DESCRIBE THE CONDITION (S):_____

PLEASE CHECK ANY CHRONIC SYMPTOMS YOU HAVE:-

- ☐ ABDOMINAL PAIN
- ☐ DIGESTIVE PROBLEMS
- ☐ FATIGUE
- ☐ SINUSITIS
- ☐ CHEST PAIN
- ☐ DIZZINESS
- ☐ INSOMNIA
- ☐ OTHER
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ MIGRAINE HEADACHES

PLEASE DESCRIBE THE SYMPTOM (S):_____

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOU, YOUR HEALTH OR YOUR BODY BEFORE ADMINISTERING MASSAGE THERAPY? PLEASE DESCRIBE:

I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow.

I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear that massage therapy is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

SIGNATURE_____ DATE_____

WELL-ADJUSTED MASSAGE INFORMED CONSENT AND PRIVACY

The following sometimes occurs during your massage:
Need to move or change positions; sighing, yawning, stomach gurgling, emotional feelings, tears, movement of gas, energy shifts, falling asleep, memories resurfacing. They are normal responses to relaxation; there is no need to be alarmed or uncomfortable. Trust your body to express itself.

Please read the following and sign below:

I understand I am receiving a therapeutic professional massage intended for general wellness purposes. I also understand that this massage should not be a substitute for an exam, diagnosis or treatment by a chiropractor or medical doctor. This is a therapeutic massage and any sexual remark or advance made will immediately terminate the session and I will be liable for payment in full of the scheduled treatment. I do understand that there are risk of unexpected results and consequential harm and forever release and hold harmless, Well-Adjusted Inc, Robert Bruce, Francine Paul, and any employee, officer or agent from all claims or causes of action for damages of whatever kind. I also understand there is a 24 hour cancellation policy and that I may be charged in full for missing an appointment without given the appropriate notification.

Signature:_____ Date:_____

Referred by:_____