Client Information

Date _____

Last Name	First	Home Phone	Birthdate
		Work Phone	
Address	Height	Weight	Age	General Health
City	State	Zip	In case of emergency, call:
			Phone:

Your Occupation	Hobbies, sports, or other activities

HEALTH PROBLEMS			IF YOU ANSWER YES TO ANY QUESTION IN THIS SECTION, PLEASE EXPLAIN	Yes	No
Do you have any of the Conditions below?	Yes	No	Have you had surgery in the last 3 years?		
Circulatory/heart problems					
Vericose Veins			Any broken bones in past 2 years?		
Arthritis					
Gout			Are you allergic to oils or lotions?		
Epilepsy					
Diabetis			Do you lack normal sensation in any body area?		
Frequent headaches					
Cancer			Are you very sensitive to touch pressure in any area?		
High Blood Pressure			Do you have any communicable disease?		
Are you wearing contacts?					

Do you have any other medical conditions that I should be aware of? Yes _____ No _____ If yes, explain below

List medications: _____

Have you received a massage before? Yes _____ No _____

Who referred you to this clinic?