CLIENT INFORMATION FORM

Name:_____ Home #:_____ Today's Date:_____
Address:_____ Work #:_____ Date of Birth:_____
City/Zip:_____ Referred By:_____

Medical Information

Do you have any history of:

YES	***NO***	
[ ]	[ ]	**Allergies(nuts, oils, medications, etc.)**
[ ]	[ ]	**Arthritis**
[ ]	[ ]	**Back Pain**
[ ]	[ ]	**Cardiac or Circulatory problems (high blood pressure, varicose veins, etc.)**
[ ]	[ ]	**Cancer (type:_____)**
[ ]	[ ]	**Contagious skin disease**
[ ]	[ ]	**Diabetes**
[ ]	[ ]	**Epilepsy**
[ ]	[ ]	**Frequent Headaches**
[ ]	[ ]	**Any other medical conditions not mentioned? (if YES, please describe)**
		_____
[ ]	[ ]	**Are you currently taking any medications? (if YES, please list)**
		_____
[ ]	[ ]	**Have you had any surgery? (if YES, please describe)**
		_____
[ ]	[ ]	**Have you had any fractures, dislocations, torn ligaments? (if YES, etc.)**
		_____
[ ]	[ ]	**Do you wear contacts?**
[ ]	[ ]	**Are you pregnant? (if YES, how many weeks_____)**
[ ]	[ ]	**Have you ever had professional massage/bodywork before?**
[ ]	[ ]	**Do you participate in a regular exercise activity? (if YES, how often:_____)**

What do you consider your problem areas to be, or where do you hold tension?

_____

What primary concern motivated you to seek massage treatment?

_____

Is there anything else you would like to share that you feel is pertinent but not covered elsewhere on this form? _____

I certify that the above information is as true and complete as I am able to provide. I agree to notify my massage therapist in the event any physical or medical changes occur. I give my massage therapist permission to notify my doctor should the need arise. I also give full permission to Bonnie M. Plant, (Lic. # 5673) to do this massage.

Client's Signature:_____ ***Date:***_____