CLIENT INFORMATION QUESTIONNAIRE

Name_____ **Occupation/Employer**_____
Date of Birth_____

Bus. _____ **Cell***_____ **Home**_____

Email Address**_____

Mailing Address_____

Hobbies/Exercise_____

Water Consumption per day_____

If you are on any medication, herbs or homeopathics; please list if so_____

ARE YOU UNDER A PHYSICIAN'S CARE? (MAY I CONTACT THEM IF SO?)_____

WHAT DO YOU DO TO REDUCE STRESS?_____
PLEASE LIST SURGERIES IN THE LAST 10 YEARS AND MAJOR ACCIDENTS_____
_____
_____

WHY DID YOU COME FOR A MASSAGE AND IF YOU HAVE HAD A MASSAGE WHEN WAS YOUR LAST ?
_____
WHERE DO YOU TYPICALLY HOLD STRESS?_____

HOW DID YOU DISCOVER OUR SERVICES?_____

DO YOU WEAR:( )CONTACT LENSES ( )DENTURES ( )HEARING AID

EMERGENCY CONTACT NAME/PHONE _____

MEDICAL HISTORY

CIRCLE CURRENT CONDITIONS. CHECK OR MARK WITH AN "X" FORMER CONDITIONS. EXPLAIN WHERE NECESSARY.

MUSCULOSKELETAL
___HEADACHE- frequency?_____
___Neck /Shoulder/ Arm Pain—Circle which one(s)
___Back Pain—(Circle) Low Mid Upper
___Arthritis (circle) Osteo / rheumatoid
Diagnosed by a Dr? __Y __N
Sprains / Strains_____
___Painful Tail Bone (coccyx)
___Stiff Neck—How long_____
___Spinal Curvature (Scoliosis)
___Jaw Pain / TMJ
__ Bursitis – Where_____
___Hernia
___Bad / Faulty Posture
___Spasms / cramps – Where_____
___Broken Bones / Fractures_____
___Fibromyalgia
___Osteoporosis - Diagnosed (date)_____
___Other_____
___Heart or Blood pressure issues_____
___Diabetes or Other serious health issues_____

GASTRO-INTESTINAL
___Constipation
___Belching or Gas
___Diverticulitis/Diverticulosis
___Hemorrhoids
___Irritable Bowel Syndrome
___Colitis
___Other_____

SKIN
___ECSEMAor Scoriosis
___Skin Allergies to _____
__Sensitive Skin
___Athletes Foot
___Bruise easily
___Rashes (Where)_____
___Skin eruptions Where)_____
___Warts (where)_____

PREGNANCIES
___Cessarian or Vaginal
___Epidural (did you have low back pain afterwards_____

On a scale of 1-10. 10 being excruciating pain. What would you rank your trouble area today?

On a scale of 1-10, what amount of pressure do you prefer?

Please sign the back of this page

There is a strict policy of 24 hour cancellation notice at a minimum or you will be billed. By signing, you are in acceptance and acknowledgement of this policy. Cancellations are to be given by phone and not email. I understand the massage services are designed to be a health aid and are in no way to take the place of doctor's care when it is indicated. Information exchanged during any massage session is educational in nature and is intended to help you become more familiar and conscious of your own health status and is to be used at your discretion.

_____

Signature Date