



CLIENT INFORMATION & RELEASE FORM

Name _____ Date: _____

Address _____

City/State/Zipcode _____

Home # _____ Work # _____ Cell# _____

E-Mail _____

Place an "X" next to the best way to contact you. Phone ___ Email ___ Text message ___

Birthdate _____ Male _____ Female _____ Marital Status _____

Occupation _____ Referred by _____

To ensure the best results from your session, please answer the following questions.

Any allergies to topical agents? Yes _____ No _____

Are you currently under treatment for any medical conditions? No _____

Yes, please explain _____

Are you taking medication? If so, please list _____

Have you had a professional massage before? Yes ___ No ___

Do you have a history of the following?

Back Pain _____

Neck Pain/Whiplash _____

Headaches _____

Numbness _____

Varicose veins/blood clots _____

High Blood Pressure _____

Injury or surgeries (within the last 5 years) _____

Diabetes _____ Wear contacts/other prosthesis? _____

Arthritis _____ Sensitivity to touch in specific areas _____

Cancer/HIV/Leukeumia _____

Are you pregnant or trying to conceive? Yes _____ No _____

Do you have any of the following TODAY?

Inflammation _____

Headache _____

Open Cuts, bruises, burns _____

Irritated skin rash/poison ivy _____

Cold/Fever _____

Please rate your consumption/participation in the following categories

	None	Light	Moderate	Heavy
Salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I am aware that massage therapy is not a substitution for medical care and that a massage therapist can not diagnose or prescribe medicines. I have, to the best of my knowledge, made the therapist aware of my health conditions. I will inform the therapist of any discomfort during the massage or of any change in my health status. I am over 18 years of age.

Signature: _____

Date: _____

Parent/Guardian (if under 18 years old): _____