

Massage Therapy Client Profile

Client Name: _____ Date of Birth: _____

Referred By: _____ Occupation: _____

Address: _____ City, State _____ Zip _____

Telephone:(Hm) _____ (Cell) _____

Email: _____ (Wk) _____

Check or Circle the Following Which Apply to You:

- | | | |
|--|---|--|
| <input type="checkbox"/> Spinal Injuries | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Neck Injuries | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Back Injuries | <input type="checkbox"/> Varicose Veins/Blood Clots | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Dislocation/ Fracture | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> HSV/Fever Blisters |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Arthritis/Bursitis | <input type="checkbox"/> Carpel Tunnel |
| <input type="checkbox"/> Arm Injuries | <input type="checkbox"/> Muscle Cramping | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Leg Injuries | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> PMS | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Other | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Contacts | <input type="checkbox"/> Dentures | <input type="checkbox"/> Pregnant _____ Due Date |

Current Doctors Treating the Medical Conditions You Stated Above: _____

Current Medications: _____

All Clients Must Sign and Read Before the Session.

I have read the following and filled out this form honestly. I understand that it is my responsibility to inform my practitioner of any physical or emotional conditions. It is also my responsibility to update any information on this form as necessary. If I experience any pain or discomfort during the session, it is my responsibility to immediately inform the practitioner. I understand that Massage Therapy is not a substitute for medical treatment or diagnosis, or for the purpose of prescribing medical treatments or medications, nor a substitute for psychiatric counseling, and nothing in the course of any session shall be construed as such. I also understand that this is a medically based massage and not a sexually based massage. There is zero tolerance for anything that might be construed as such. If at any time the practitioner feels the need to end the session, they shall do so.

Cancellation Policy: 24 Hours notice must be given on all cancellations. If 24 hours is not given, client will be responsible for 100% of appointment fee.

Client's Signature: _____ Date _____

Therapist's Notes: