CLIENT INFORMATION RECORD

Name: ____ **Date:** _________________

Address: ______________________________________ **City:** ___________________ **State:** _____ **Zip:** __________________

Phone: ___________________________________ **Email:** ____

Occupation: ___________________________________ **DOB:** ______________________________

Emergency Name & Number: ____

Previous experience with massage? [ ] YES [ ] NO **Rate Your Experience:** [ ] Poor [ ] Fair [ ]Good [ ]Excellent

Primary reason for appointment? ____

Do you currently have pain? ________ **If yes, circle one on Pain Scale:**

No Pain- 0 1 2 3 4 5 6 7 8 9 10= Worst Pain

Check all those that apply to you currently:

_____ Headaches, Migraines	_____ Chronic Pain	_____ Fatigue
_____ Vision problems	_____ Muscle Pain	_____ Joint
_____ Tension/Stress	_____ Muscle injuries	_____ Bone injuries
_____ Deafness	_____ Depression	_____ Rotator Cuff injury
_____ Numbness or tingling	_____ Trouble sleeping	_____ Sinus Problems
_____ Sprains	_____ Strains	_____ Allergy/Sensitivity
_____ Arthritis	_____ Tendonitis	_____ Rashes, Athletes Foot
_____ Infectious disease	_____ Asthma, Lung Conditions	_____ Jaw pain, TMJ
_____ Blood clots	_____ Constipation, Diarrhea	_____ Diabetes
_____ Hernia	_____ High blood pressure	_____ Heart attack
_____ Heart conditions	_____Circulatory problems	_____ Digestive problems
_____ Abdominal problems	_____ Fibromyalgia	_____ Mental Illness
_____ Spinal Column Disorders	_____ Other not listed : ______________________________________	

Explain Condition/s not listed: ____

Current Medications (ie. Blood thinners, pain killers, anti-depressants):

____

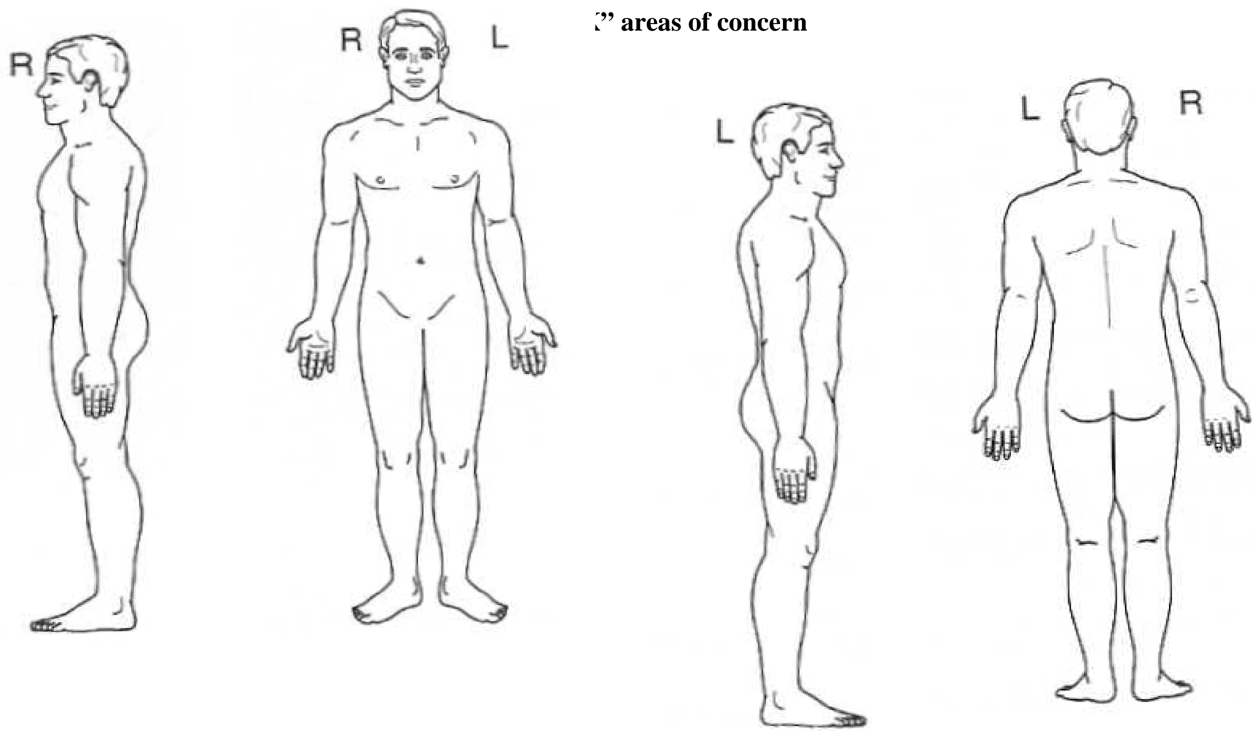
Have you ever had cancer ? [YES] [NO] **Type:**____

Date diagnosed: _____________ **Time Recovered:** _______________ **WBC (4.5-10):** _________ **PLT (150-450):** ___________

Treatment/s:____

Were any lymph nodes removed/irradiated? [YES] [NO] **If yes, Neck** [ ] **Armpit** [ ] **Groin** [ ]

:” areas of concern



Explanation: ____

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