Client Registration & Health Form

Name: ..... Date: .....

Address: ..... Day Phone: .....

City, State, Zip: ..... Evening Phone: .....

☐ Male ☐ Female Date of Birth: ..... E-mail: .....

Ins Co & Claim #: ..... Date of Injury: .....

Occupation: ..... Employer: .....

Emergency Contact: ..... Phone: .....

How did you hear about us: .....

Primary Health Care Provider: ..... Phone: .....

Approximate date of your last visit to your health care provider: .....

List current medications, including aspirin, ibuprofen, etc. .....

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Have you ever had a massage or other type of bodywork before? ☐ No ☐ Yes, Type: .....

What results do you want from your massage sessions? .....

List stress reduction and exercise activities, including frequency. .....

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Please check whether you currently have or have had any of the following conditions: (use back if more space is needed)

☐ HIV positive	☐ cancer/tumors	☐ diabetes	☐ hepatitis	☐ infectious diseases
☐ headaches	☐ migraines	☐ stroke	☐ blood clots	☐ high blood pressure
☐ heart attack	☐ varicose veins	☐ broken bones	☐ depression	☐ currently pregnant
☐ rashes	☐ warts	☐ herpes	☐ shingles	☐ athlete's foot
☐ herniated disk	☐ ruptured disk	☐ arthritis	☐ bursitis	☐ numbness & tingling
☐ neck pain	☐ back pain	☐ hip/leg pain	☐ shoulder/arm pain	☐ TMJ pain

Please list all relevant surgeries and accidents, year and treatment received:

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Habits:	**Mild**	**Moderate**	**Heavy**
Alcohol/Recreational Drugs	☐	☐	☐
Caffeine/Chocolate/Tea/Coffee	☐	☐	☐
Tobacco	☐	☐	☐
Water	☐	☐	☐
Junk Food	☐	☐	☐
Exercise	☐	☐	☐

It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree that communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner regarding any changes in my health status.

Signature _____ Date _____