CLIENT QUESTIONNAIRE

*NAME:*_____

*ADDRESS:*_____
SREEET CITY STATE ZIP

*HOME PHONE:*_____ *BUSINESS PHONE:*_____

*OCCUPATION:*_____ *EMERGENCY CONTACT:*_____

*MALE*_____ *FEMALE*_____ *WEIGHT*_____ *HEIGHT*_____ *D.O.B.*_____

REASON FOR COMING TO CLINIC TODAY:_____

_____

REFERRED BY :_____

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE? YES_____NO____IF YES, DATE OF LAST?_____

ARE YOU ALLERGIC TO ANYTHING? YES_____NO_____ IF YES, WHAT? _____

ANY PHYSICAL PROBLEMS OR INJURIES? _____

_____

HAVE YOU SEEN A DOCTOR FOR ANY REASON IN THE PAST TWO YEARS? YES_____NO_____
IF YES, GIVE DETAILS ON THE BACK OF THIS PAGE PLEASE.

CIRCLE ANY ITEM BELOW THAT IS IN YOUR PRESENT OR PAST HISTORY

APPENDICITIS	HEADACHES	CIGARETTES	SKELETAL DISORDERS
ARTHRITIS	HEART PROBLEMS	ULCERS	NERVOUS DISORDERS
BACK PAIN	INSOMNIA	WHIPLASH	THROMBOPHLEBITIS
CANCER	OBESITY	DIVERTICULITIS	DIGESTIVE DISORDERS
CONSTIPATION	SKIN DISEASE	MEDICATIONS	HIGH BLOOD PRESSURE
DIABETES	SURGERY	CIRCULATORY PROBLEMS	

OTHER:_____

I UNDERSTAND THAT ALL TREATMENTS ARE GIVEN BY A LICENSED MASSAGE THERAPIST. I RELEASE THIS CLINIC AND ITS STAFF FROM ANY LIABILITY DUE TO INJURY OR OTHER CAUSES RESULTING FROM THE EXERCISE OF THEIR DUTIES AND I EXPRESSLY GIVE MY PERMISSION FOR THIS TREATMENT.

_____ _____
SIGNATURE DATE