MAIN STREET
MASSAGE THERAPY

Client Information Form

DATE: ______________

NAME: ____ D.O.B: ______________

ADDRESS: ______________________________CITY: ______________ STATE: _____ZIP: ________

DAY PHONE NUMBER: ____________________EVENING PHONE NUMBER: ____________________

OCCUPATION: ______________________________EMPLOYER: ________________________

REFERRED BY: ______________________________ EMAIL:___________________________

HAVE YOU HAD A MASSAGE BEFORE: __________ IF YES, HOW MANY: ______________________

PRIMARY REASON FOR APPOINTMENT: ____

ARE YOU LOOKING FOR (CIRCLE ALL THAT APPLIES):

RELAXATION • INCREASED FLEXABILITY • PAIN RELIEF • INCREASE RANGE OF MOTION

DO YOU PREFER LIGHT, MEDIUM, OR DEEP PRESSURE? ____________________________________

EMERGENCY CONTACT- NAME, NUMBER & RELATION: ____________________________________

PLEASE INDICATE IF YOU CURRENTLY HAVE (X) OR PREVIOUSLY HAVE HAD (P) ANY OF THE LISTED CONDITIONS:

___HEADACHES / MIGRAINES
___HEARING PROBLEMS / DEAFNESS
___INJURIES TO FACE OR HEAD
___SINUS PROBLEMS
___DENTAL BRIDGES / BRACES
___JAW PAIN / TMJ PROBLEMS
___ASTHMA OR LUNG CONDITIONS
___HEART / CIRCULATORY PROBLEMS
___DIABETES

___CHRONIC PAIN
___MUSCLE/JOINT INJURIES OR PAIN
___TENSION OR STRESS
___NUMBNESS OR TINGLING
___ARTIFICIAL JOINTS
___SPRAINS OR STRAINS
__ _ARTHRITIS OR TENDONITIS
___CANCER / TUMORS
___SPINAL COLUMN DISORDERS
___ALLERGIES OR TENDONITIS

___RASHES / ATHLETES FOOT
___INFECTIOUS DISEASE
___BLOOD CLOTS
___VARICOSE / SPIDER VEINS
___HIGH / LOW BLOOD PRESSURE
___FATIGUE
___DEPRESSION
___PREGNANCY
___FIBROMYALGIA

EXPLAIN ALL MARKED CONDITIONS: ____

____

CURRENT MEDICATION INCLUDING ASPIRIN, IBUPROFEN, HERBS, SUPPLEMENTS, ECT: ______________

____

SURGERIES: ____

HOBBIES: ____