

New Client Information and Release Form

Name: _____

Address: _____

City, State, Zip: _____

Cell: _____ Work/Home: _____ DOB: _____

Email: _____ Occupation: _____

Referred by: _____

In case of emergency contact: _____ Phone # _____

Please answer the following questions:

Yes No Have you had massage previously?

Yes No Do you suffer from headaches?

Yes No Are you diabetic?

Yes No Do you have high blood pressure?

If yes, are you taking blood pressure medication? Yes No

Yes No Are you epileptic?

Yes No Are you taking pain medication?

Yes No Do you suffer from back pain/injury?

Yes No Do you have any cardiac/circulatory problems?

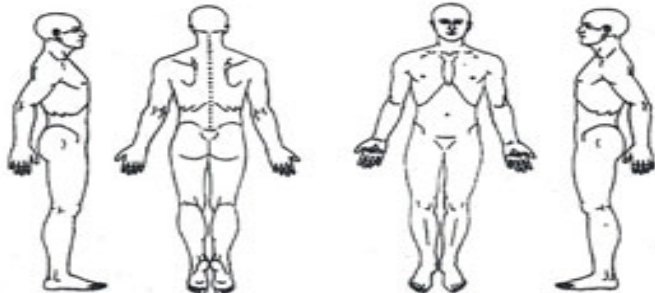
Yes No (Females) Are you pregnant? If yes, how far along? _____

Use this space to clarify answers above: _____

List prior surgeries or broken bones in the last two years: _____

Other conditions therapist should be aware of: _____

Circle areas of pain, tension, or soreness.



I understand that massage should not be performed due to certain medical conditions. I have stated all my known medical conditions, and answered all questions thoroughly. I agree to keep the therapist updated if my medical conditions change in the future. I further understand that massage therapy is not a substitute for medical examination, diagnosis, or treatment by a physician. If I experience any pain or discomfort during the session, I will inform the practitioner so the massage can be adjusted to my comfort level.

Signature _____

Date _____