(585) 292-6428

Client Information

In order to maximize the effectiveness and safety of your massage session, please take the time to carefully complete this questionnaire. This information will be treated confidentially. Your feedback is appreciated.

Name:______________________________________ DOB:__________________ Referred By:___________________

Address:____________________________________ City:_________________ State:____________ Zip:_________

Occupation:________________________________ Home #:______________ Cell #:____________ Work #:_________

Email Address:______________________________

Emergency Contact: ___________________________ Relationship ____________________ Phone #:_________________

Are you pregnant now or attempting to get pregnant? ( ) Y ( ) N Have you had a professional massage before? ( ) Y ( ) N

What are your goals/concerns for today's session? ____

____

Check any of the following that my apply _______ Stress _______ Pain ________ Stiffness ________ Other _______________

Please check any of the following conditions that you have now or had recently

____ allergies
____ arthritis
____ bursitis
____ cancer
____ diabetes
____ edema
____ herniated disc

____ headaches
____ sinusitis
____ neck pain
____ chest pain
____ blood clots
____ heart condition

____ sciatica
____ fainting spells
____ loss of balance
____ broken bones
____ abdominal disorder
____ osteoporosis

____ varicose veins
____ high blood pressure
____ shortness of breath
____ menstrual pain/PMS
____ skin disorders/conditions
____ numbness hands/feet

Please state any recent injuries, medical treatments or conditions (not listed above)____________________________________

____

Are you under medical care or supervision at this time? ( ) Y ( ) N If so what for? ______________________________

____

Are you currently taking any medication? ( ) Y ( ) N If so, please list: ______________________________________

____

Physician Name:_______________________________________ Phone #:___________________________________

Do you wear ( ) contacts, ( ) dentures, ( ) hearing aid?
Do you experience any difficulty lying on your ( ) back, ( ) front, ( ) side?

PLEASE READ THE FOLLOWING AND SIGN BELOW

I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment.
I understand that payment in full is expected at the end of my session, unless prior arrangements have been made.
I understand I am responsible for payment of any appointment cancellation or forfeiture of gift certificate with less that 24 hours notice.
I understand that inappropriate actions or language is cause for termination of my session.
We reserve the right to refuse service to anyone for any reason.

I give my consent to receive treatment ____ **Date**__________________