

CONFIDENTIAL CLIENT INFORMATION FORM:

Name _____

Address _____

Phone _____ Email _____

Occupation _____ Date of Birth _____

Referred by _____ Emergency Contact: _____

To better serve your specific needs, please take time to answer the following questions:

Is this your first professional massage? _____ If no, date of last massage? _____

Does your job require you to sit or stand for long periods of time? _____

Do you use a computer and/or a cell phone frequently? _____

Do you participate in any activities, i.e. running, walking, basketball, yoga, biking, softball, etc? _____

If so, please list _____

What level of pressure do you prefer? _____ Light/Moderate/Heavy/Deep

What are your goals for massage treatment? _____

Are there any areas of the body you DO NOT like to have massaged? _____

Are you allergic to any aromas or oils? _____ If so, please list _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? IF SO, PLEASE CIRCLE

Arthritis	Diabetes	High Blood Pressure	Osteoporosis	Sports Injury
Blood Clots	Fibromyalgia	Infectious Condition	Physical Injury	TMJ Syndrome
Cancer	Headaches	Lupus	Pregnancy	Ulcers
Cold/Flu/Fever	Heart Condition	Neck/Back Pain	Skin Disorder	Varicose Veins

Please give a brief description of all circled conditions above _____

List any other medical conditions you are currently being treated for, as well as any medications: _____

I understand that massage/bodywork therapy is for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist. I understand that massage/bodywork practitioners are not qualified to diagnose, prescribe or treat any physical or mental illness, and nothing said during the course of the session(s) should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there is no liability on the part of the therapist or Your Essential Harmony LLC.

Client Signature _____ Date _____