

CONFIDENTIAL CLIENT INFORMATION

MESSAGE THERAPIST:
DATE:

Name		
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Birthday (Y/M/D)	Phone (home)
Address		Phone (work)
City		Zip/Postal Code
Occupation		Employer
Height	Weight	Blood Pressure
Referred by		

Medical History (list present/previous illnesses, accidents, surgeries, fractured bones)	
Are you presently on any medications?	
Medical Doctor	Chiropractor
Physiotherapist	Other Health Care Provider
Previous Massage Experience Y N	Comments

Purpose of this appointment (major complaint)	
When did these symptoms appear?	
Have you ever had same or similar condition? Y N If yes, when, and describe	
How is this condition interfering with your daily routine?	
Is it progressively getting worse? Y N Constant? Comes & goes?	
What makes it worse?	
What makes it better?	
Other complaints?	

THIS IS A 2-PAGE FORM.