



Client Information Form

Date: _____

Client Contact Information

Client Name: _____ Date of Birth: _____ Gender: _____

Address: _____ Zip: _____

Phone: _____ (Cell ☐) Email: _____

May we send you text messages? Yes ☐ No ☐ May we send you emails? Yes ☐ No ☐

How did you hear about us?: _____

Emergency contact:

Name: _____ Relationship: _____

Phone: _____ (Cell ☐)

Is this bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Do you have a nut allergy? Yes ☐ No ☐

Do you have a latex allergy? Yes ☐ No ☐

General Health Information

Have you ever received professional bodywork before? Yes ☐ No ☐

Acupuncture ☐ Massage ☐

How recently? _____

What are your goals/expected outcomes for receiving bodywork?

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your activities of daily living (i.e., sleep, exercise, work, childcare)? Yes No
Explain:

List any medications, birth control, HRT, Herbs or supplements you currently take:

How often do you exercise? _____ What type of exercise? _____

On a scale of 1 to 10, with 1 being the lowest, rate your energy level: _____

Please list any injuries, accidents, or hospital treatment that may affect your treatment:



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