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:

____
____
____

MEMBER
Associated Bodywork & Massage Professionals