For office use only: TYN _____ DAPC _____ IFR _____ THERAPIST _____

Therapeutic Massage Centre

NEW CLIENT FORM

Name: _____ Date: _____

Email: _____ Phone: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Age: _____ Gender: ☐Male ☐ Female

Marital status: _____ Number of children: _____ Ages: _____

Occupation: _____ Employer: _____

Partner/Spouse: _____ Partner's occupation: _____

Referred by: _____

Purpose of visit (check all that apply):

☐ Stress reduction ☐ Sports injury ☐ Therapeutic massage

☐ Illness / disease ☐ Accident ☐ Prenatal massage

Have you ever received massage therapy? ☐ Yes or ☐ No

Chiropractic care? ☐ Yes or ☐ No
If yes, please describe your experience: _____

Are you now under medical/therapeutic treatment? ☐ Yes or ☐ No For what condition? _____

Primary care physician: _____ Phone: _____

Are any areas of your body prone to injury? _____ Which ones? _____

Are you on medication? Which medications? _____

Are you wearing contact lenses? ☐ Yes or ☐ No

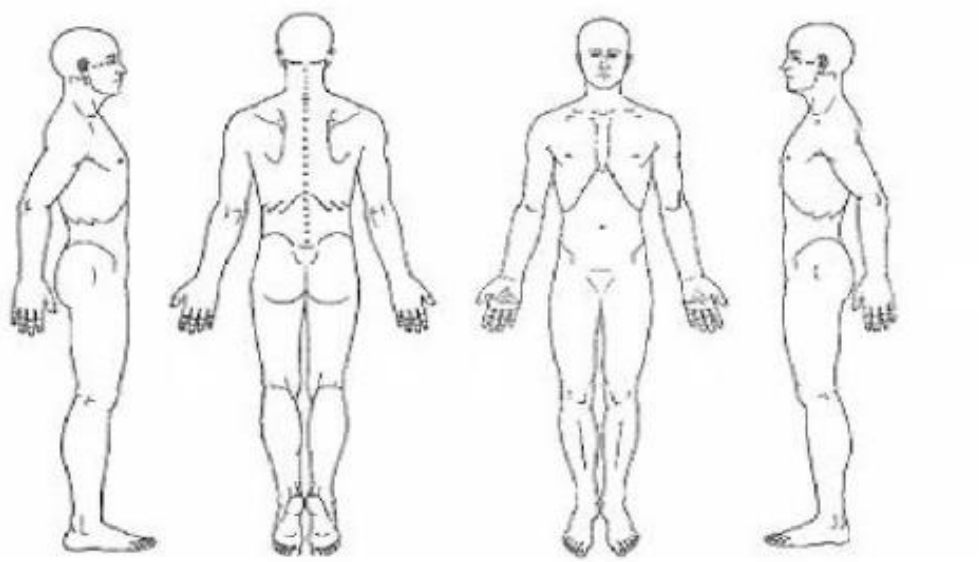
Have you had any of the following? (Please note duration of symptoms and/or diagnosis date.)

- □ Allergies to oils/perfumes
- □ Varicose veins
- □ Decreased range of motion
- □ Nervous tension
- □ Abdominal pain
- □ Neck/mid/lower back pain
- □ High blood pressure/stroke
- □ TMJ dysfunction
- □ Heart or lung disorder
- □ Headaches
- □ Diabetes
- □ Pregnancy
- □ Sprains
- □ Accidents
- □ Arthritis
- □ Seizures
- □ Fibromyalgia
- □ Numbness/tingling
- □ Whiplash
- □ Joint ache
- □ Constipation
- □ Broken Bones
- □ Operations
- □ Carpal Tunnel syndrome
- □ Hearing problems
- □ Sciatic pain
- □ HIV/AIDS

AREAS OF PAIN:

Circle areas of pain

N – Write in areas of numbness
A – Write in areas that ache
S – Write in areas of muscle spasm or joint stiffness



Rate the pain on a scale of 1-10 with 10 being the most severe: _____

☐ Relaxation only

Additional Comments: _____

Are you experiencing any of the following?

□ Skin rash □ Sunburn □ Open cuts/bruises □ Inflammation

Habits, please mark the habits you participate in and the degree by indicting.
***(H** for Heavy, **M** for Moderate, **L** for Light and **N** for None)*

Alcohol: ____ Caffeine: ____ Tobacco: _____ Exercise: ____ Sugar consumption: _____ Water: _____

What types of sports do you participate in? _____ Are you in a training program? □ Yes or □ No
How often do you work out? _____ What kind of exercise is it? _____

Please initial:

_____ I have listed all known medical conditions and physical limitations and I will inform my therapist of any changes. I understand that a massage therapist diagnoses neither illness, disease, nor any other medical, physical or mental disorder. Furthermore, I am responsible for consulting a qualified physician for any physical ailments I may have.

_____I agree to pay for all services at the time they are rendered unless prior arrangements have been made. I understand that under all circumstances, it is my responsibility to see that any services rendered to me are paid for by myself or another party.

FOR THE MASSAGE THERAPIST

Subjective (Client goals/update)

ROUTINE: 1 wk 2 wks 3 wks 4 wks
Next appointment scheduled? □ Yes or □ No
Follow up with client? □ Yes or □ No
Date: _____

Observations

MASSAGE:
Supine Prone Full Body Upper body only

Other: _____

Assessment

Reiki Swedish Deep tissue Myofascial release
NMT Reflexology CransSac Lymph drainage TMJ

Plan
(suggested treatment plan)

Homework: _____
_____
_____