

Rejuvenate Massage Therapy
Confidential Client Information

Name _____ DOB: ____/____/____
Address _____
Home Phone _____ Work Phone _____ Cell _____
Email _____ Height _____ Weight _____
Referred By _____ Marital Status: _____
Employer _____ Occupation _____
Is this your first professional massage? Yes/No Date of last massage: _____
Desired results of today's session: _____

Please list any injuries, broken bones or surgeries and date they occurred

Please circle any of the following conditions you are experiencing:

Emotional Changes	Headaches	Skin Disorders
Hypoglycemia	Phlebitis	PMS
Heart Ailment	Diabetes	Pregnancy
Infectious Condition	Sleeplessness	Flu/Cold/Fever
Kidney Ailment	Allergies	High Blood Pressure
Cancer	TMJ Syndrome	Varicose Veins
Chronic/Acute Pain	Digestive Problems	Arthritis
Neck/Spine Injury	Ulcerated Colon	Osteoporosis
Fibromyalgia	Joint Discomfort	Carpal Tunnel Syndrome
Other _____		

Are you currently under the care of a Health Professional? Yes/No Name: _____

Have you ever seen a Chiropractor before? Yes/No How Recently: _____

Please list any medications _____

What types of exercise do you do and how often? _____

I understand that if I experience any pain or discomfort during my session/s, I will immediately inform the therapist in order for the pressure &/or strokes to be adjusted to my level of comfort. I further understand massage/bodywork should not be considered a substitute for medical examination, diagnosis or treatment. I should see a qualified medical specialist for any mental or physical ailment that I experience. I understand massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose or treat any physical or mental illness or to prescribe any medications; nothing said during the session/s should be interpreted as such. Because massage/bodywork should not be done under certain medical conditions, I affirm that I have stated all of my known medical conditions & have answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for FULL payment of the scheduled appointment.

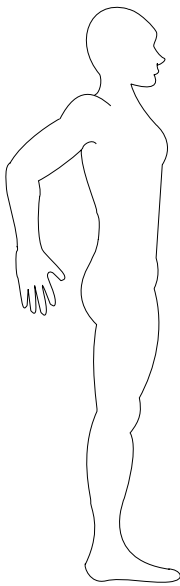
Client Signature _____ Date _____
Parent Signature _____ (Required if client under 18 years old)

Client Status Report

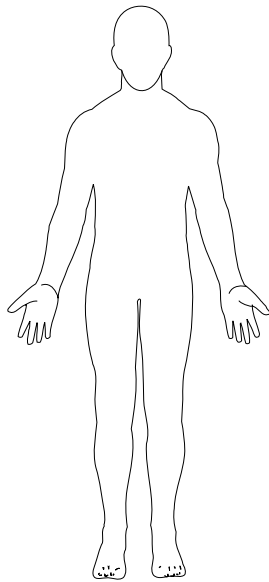
Name: _____ Date: _____

Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below.

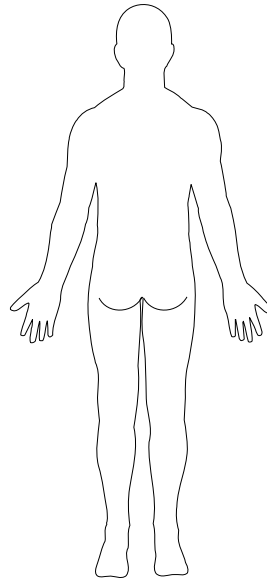
- Key**
- Circle areas where **pain** exists
 - ⊙ Circle areas with small dots where **extreme pain** exists
 - × Put an "X" over **stiff** areas
 - ⋯ Draw squiggly lines over areas of **numbness** or **tingling**
 - ⊥ Mark **scars, bruises** or **wounds**



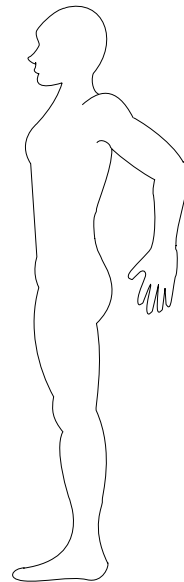
Right



Front



Back



Left

Comments: _____

