Date:_____

New Client Information

Name:_____ D.O.B._____ Sex: M F

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

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____ Driver's License #:_____

Occupation:_____ Referred By:_____

Emergency Contact Name & Phone #:_____

How active do you consider yourself?_____ What is your typical energy level?_____

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

What are your hobbies? _____

Please list any **sports** or **instruments** you play currently or have played in the past.

Current:_____

Past:_____

Please list any injuries you've suffered, including repetitive strains:

_____

Does your work or any frequent activities you do involve the following: **(Please Circle All that Apply)**

long hrs	stress	typing	extended sitting	computer work	head-down posture	head-up posture	
telecommunication	pushing/pulling	gripping	reaching	stooping/bending	kneeling	stretching	crawling
extended standing	balancing	extended walking	climbing	extended running	lifting/loading	carrying	

Do you experience frequent discomfort while: **(Please Circle All that Apply)**

standing	sitting	walking	running	jumping	climbing	laying face down	laying face up	sleeping

List any other activities you think may affect your physical well-being: _____

Therapist Notes

Date:_____

Massage History/Session Information

Have you ever received a professional massage? Y N Date of last massage:_____

What (if any) types of massage have you experienced?_____

What did you like/dislike about your previous massage experiences? _____

_____

What is the reason for today's visit? **(Please Circle All that Apply)**

Stress Relief/Relaxation	Pain Relief	Sports Massage/Invigorating	Postural Improvement	Injury Rehab

Where do you typically feel pain/tension? _____

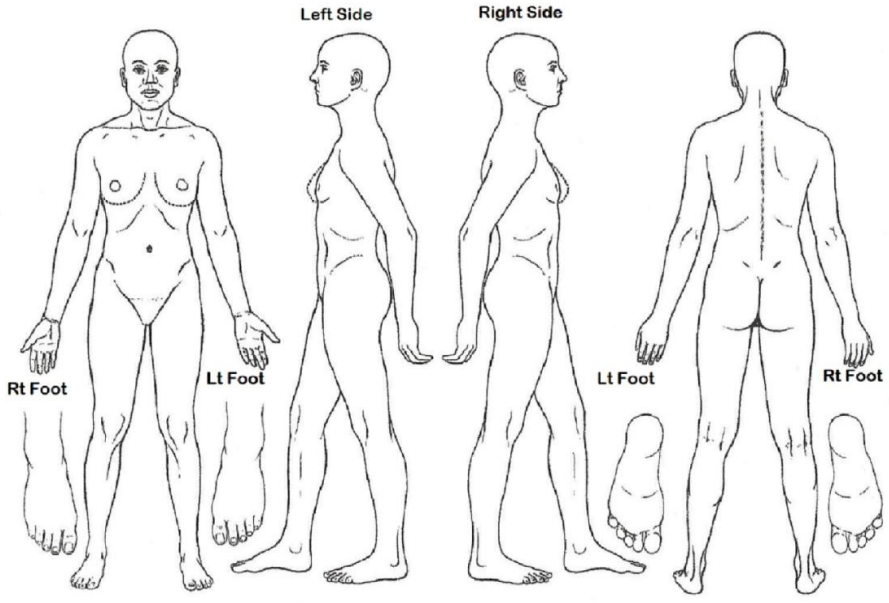
What results would you like from your massage session(s)? _____

List allergies to any types of lotions, oils, or nuts: _____

List any skin conditions & locations:_____

Are you warm or cold natured?_____

Please <u>circle</u> any areas of frequent/common pain, stiffness, or discomfort.
Mark with "X" in areas of current pain, stiffness, or discomfort.



Therapist Notes