





**CHRISTUS
SPOHN MASSAGE THERAPY**
CLIENT INFORMATION FORM

Name _____ Date of birth _____

Home Address _____
Street City State ZIP

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

Please answer the following questions by checking the appropriate answer:

Have you had a professional massage?

Yes No

Do you wear contact lenses?

Yes No

Have you suffered an acute injury recently?

Yes No

Are you pregnant

Yes No

Have you had recent surgery?

Yes No

What Kind? _____

Do you have any skin problems or known
allergies to oil?

Yes No

Do you have varicose veins or blood clots?

Yes No

Do you exercise regularly or participate
in any sports?

Yes No

Do you have blood pressure problems?

Yes No

Do you have tense or sore areas that need special
attention?

Yes No

Do you have any other medical condition that I should
be aware of before giving you a message?

Yes No

I understand that massage therapy given here is for the purpose of stress reduction. Relief from muscular tension or spasm or for increasing circulation and energy flow.

In understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder as such the massage therapist does not prescribe medical treatment or pharmaceuticals. Nor do they perform any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medial examinations and/or diagnosis and that it is recommended that I see a physician for an ailment that I might have.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____

Date _____