Client Information

Today's Date: _____/_____/_____

Name: _____ **DOB:** _____/_____/_____ **Sex:** **M** **F**

(First) (Last)

Address: _____ **APT**_____

City: _____ **State:** _____ **Zip:** _____

Email: _____ **Preferred**

(Please Print Clearly) **Contact**

Occupation: _____ **Home Phone: (_____)** _____ ☐

Cell Phone: (_____) _____ ☐

Emergency Contact: _____

(Name & Phone Number)

The following information will allow your therapist to provide you with the best session possible.

This information is strictly confidential to Chester County Therapeutic Massage staff. We do not share information with any other outside individuals or companies.

Please share your goals for this session_____

Do you perform repetitive movements in your work, sports, or hobby?	**Y**	**N**
Do you sit for long hours at a computer or while driving?	**Y**	**N**
Are you currently experiencing tension, stiffness, discomfort or pain?	**Y**	**N**
If yes, do you limit your movement in anyway?	**Y**	**N**
Have you been involved in a motor vehicle accident in the past 12 months?	**Y**	**N**
Have you recently had any injury, surgery or areas of inflammation?	**Y**	**N**
Do you bruise easily?	**Y**	**N**
Do you have sensitive skin?	**Y**	**N**
Are you currently pregnant or is there a possibility you could be pregnant?	**Y**	**N**
If yes, how many weeks? _____		
Have you had a professional massage before?	**Y**	**N**

Health History (please check any conditions you have experienced in the past 12 months, or are currently experiencing)

___Jaw Pain
___Carpal Tunnel Syndrome
___Headaches/Migraines
___Osteoporosis
___Arthritis
___Heart Condition
___Varicose Veins/Phlebitis
___Blood Clots
___High/Low Blood Pressure
___Asthma
___Allergies
___Whiplash
___Spinal Stenosis
___Sinus Problems
___Numbness/Tingling
___Pinched Nerve
___Paralysis
___Multiple Sclerosis
___Parkinson's Disease
___Fibromyalgia
___Muscle Strains
___Athlete's Foot
___ Herpes/Cold Sores
___Shingles
___Disc Bulge/Herniation
___Ligament Sprains
___IBS
___Bladder/Kidney Ailment
___Colitis
___Crohn's Disease
___Ulcers
___Anxiety/Stress
___Depression
___Diabetes
___Cancer/Tumors
___ Tourette Syndrome
___Autism/Asperger's Syndrome
___Skin Rash
___Rotator Cuff Tear

(Continued on Reverse) ⇨

Please use this space to list any other conditions or details on those checked on previous page: _____

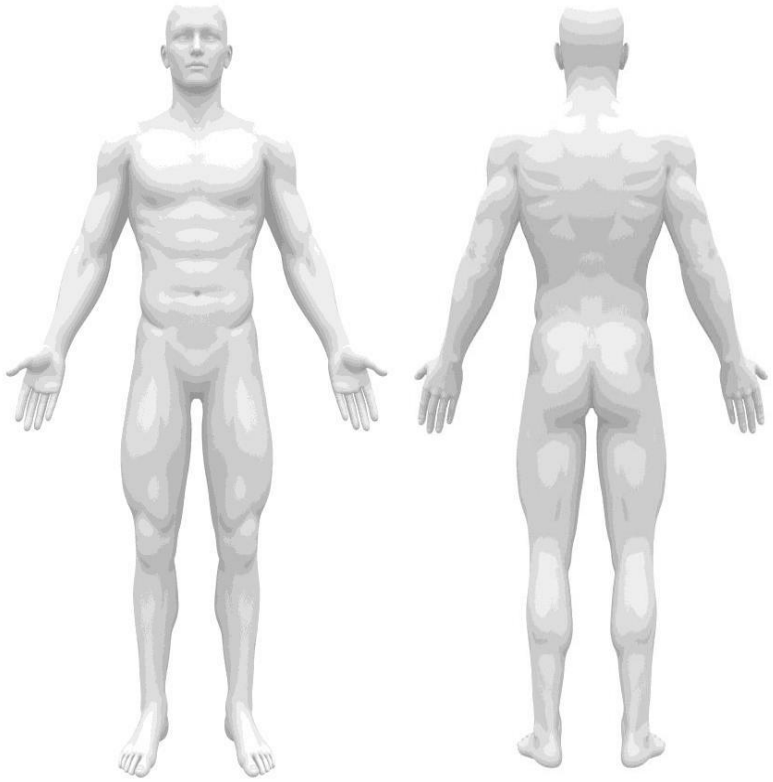
_____

_____

Please list all current medications: _____

Please list any allergies: _____

Please list any sports or exercise you participate in regularly: _____



Please mark, on the diagram, any specific areas in which you are experiencing soreness, pain or discomfort.

Feel free to provide any details as necessary._____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I understand that any therapy session I receive with Chester County Therapeutic Massage, is strictly for the basic purpose of relaxation and relief from stress and tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist. I affirm that I have stated all known medical conditions and understand that there shall be no liability on the therapist's part if massage is contraindicated.

I am aware that in some instances a physician's consent form may be required for massage therapy.

I also understand that all therapy sessions are strictly therapeutic and that any illicit or sexually suggestive remarks or advances on my part will result in immediate termination of the session and I will be liable for payment in full.

I am aware that I am required to give a minimum of four (4) hours notice to cancel/re-schedule any appointments, regardless of when they were made. I will be responsible for full payment if failing to do so.

Special Note: All massage therapists are under contract with Chester County Therapeutic Massage and not legally permitted to independently massage any Chester County Therapeutic Massage client without written consent from the owner.

X_____ **Date**_____

Signature of Client

Who can we thank for your visit? **Referred by:** _____