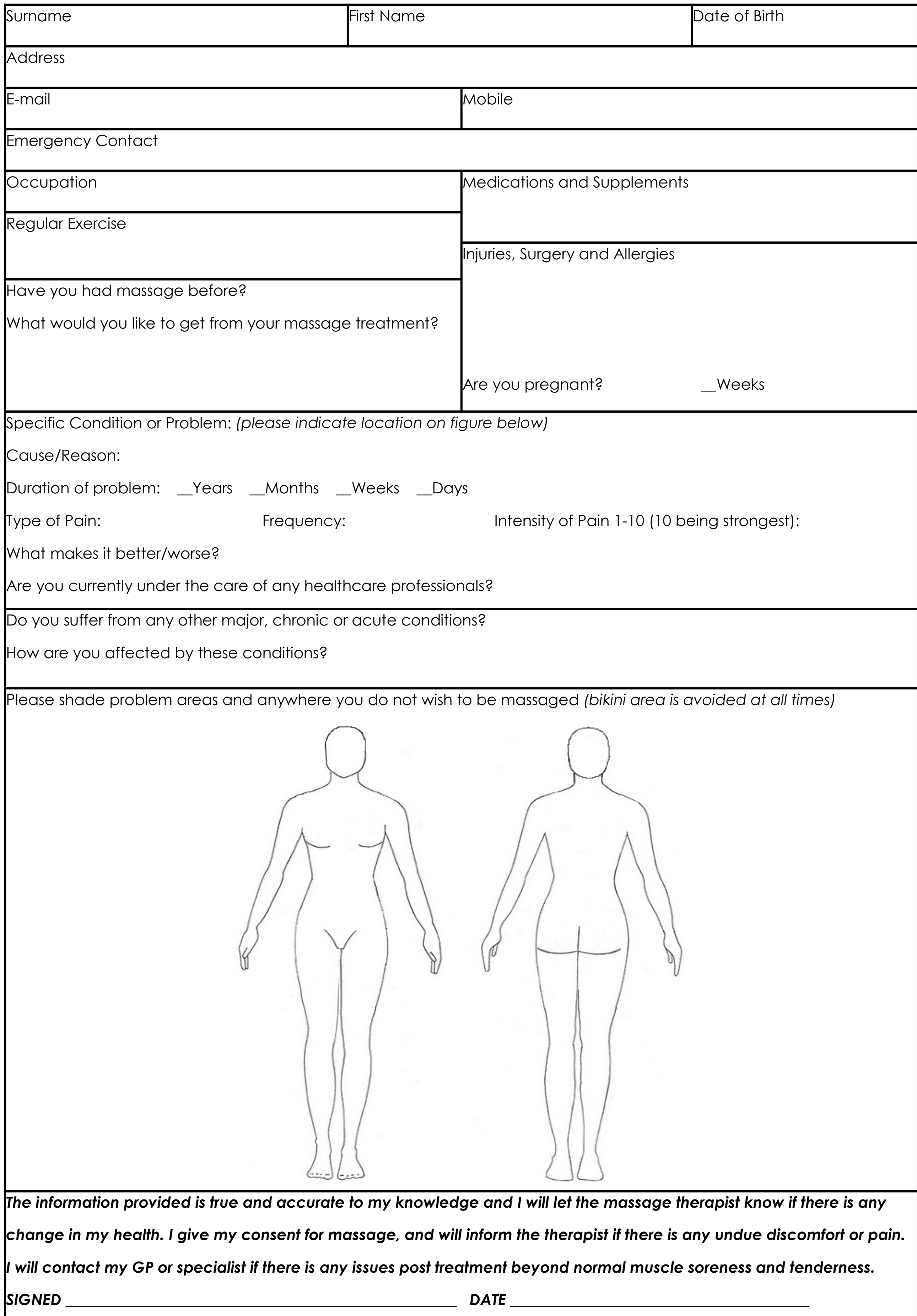

CONFIDENTIAL CLIENT INFORMATION

Surname	First Name	Date of Birth

Address

E-mail	Mobile

Emergency Contact

Occupation	Medications and Supplements
Regular Exercise	Injuries, Surgery and Allergies
Have you had massage before? What would you like to get from your massage treatment?	Are you pregnant? __Weeks

Specific Condition or Problem: *(please indicate location on figure below)*

Cause/Reason:

Duration of problem: __Years __Months __Weeks __Days

Type of Pain: Frequency: Intensity of Pain 1-10 (10 being strongest):

What makes it better/worse?

Are you currently under the care of any healthcare professionals?

Do you suffer from any other major, chronic or acute conditions?

How are you affected by these conditions?

Please shade problem areas and anywhere you do not wish to be massaged *(bikini area is avoided at all times)*

The information provided is true and accurate to my knowledge and I will let the massage therapist know if there is any change in my health. I give my consent for massage, and will inform the therapist if there is any undue discomfort or pain. I will contact my GP or specialist if there is any issues post treatment beyond normal muscle soreness and tenderness.

SIGNED ____ ***DATE*** ___________________________________