

U M M A S S A G E
Confidential Client History

Name _____ DOB _____ Date _____

Address _____

Telephone (H) _____ (cell) _____ email _____

Occupation / Occupational Activity (e.g. Heavy Lifting) _____

How did you hear about me? _____

Primary reason for appointment _____

Areas of complaint, pain or tension _____

Primary Care Physician _____ Telephone _____

Medications you are currently taking _____

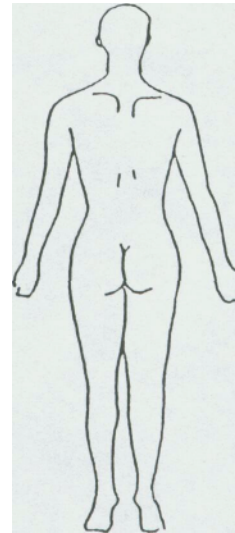
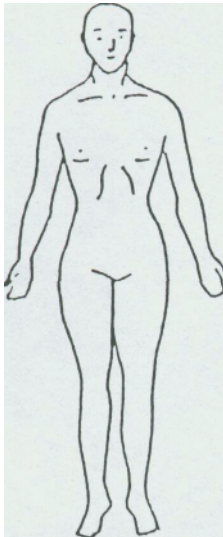
Do you wear contacts? _____ Dentures? _____

On a scale of 1 to 10 (1 is the least), rate the amount of stress or tension in your life? _____

Have you ever had a muscular therapy treatment before? Was there anything you particularly liked/disliked?

Is there anything else that would be helpful for me to know? _____

PLEASE MARK YOUR AREAS OF COMPLAINT, PAIN OR TENSION



I verify that all information provided is correct to the best of my knowledge. I understand that any information provided by the therapist is for educational purposes only and is not prescriptive or diagnostic in nature. I hereby give my consent to receive therapeutic massage. I am also aware of the 24 hour cancellation policy.

Signature

Date