



# Client Information Form

Date: \_\_\_\_\_

### Client Contact Information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ (Cell ) Email: \_\_\_\_\_

May we send you text messages? Yes  No  May we send you emails? Yes  No

How did you hear about us?: Groupon  Facebook  Yelp  Google  FiveStars

Friend/Family  \_\_\_\_\_ Other  \_\_\_\_\_

Emergency contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ (Cell )

Is this bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes  No

Do you have a physician referral/prescription? Yes  No

Do you have a nut allergy? Yes  No

Do you have a latex allergy? Yes  No

### General Health Information

Have you ever received professional bodywork before? Yes  No

Acupuncture  Massage

How recently? \_\_\_\_\_

What are your goals/expected outcomes for receiving bodywork?

\_\_\_\_\_

\_\_\_\_\_

How do you feel today? \_\_\_\_\_

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

\_\_\_\_\_

\_\_\_\_\_

Do these symptoms interfere with your activities of daily living (i.e., sleep, exercise, work, childcare)? Yes No

Explain:

\_\_\_\_\_

\_\_\_\_\_

List any medications, birth control, HRT, Herbs or supplements you currently take:

\_\_\_\_\_

\_\_\_\_\_

How often do you exercise? \_\_\_\_\_ What type of exercise? \_\_\_\_\_

On a scale of 1 to 10, with 1 being the lowest, rate your energy level: \_\_\_\_\_

Please list any injuries, accidents, or hospital treatment that may affect your treatment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

