CLIENT INFORMATION

Name_____DOB_____ Date_____

Address_____City_____Zip_____

Phones(H/W/C)_____Email_____

MD_____permission to contact?___ Phone_____

DC or other_____permission to contact?___ Phone_____

Referred by _____permission to contact?___ Phone_____

Emergency contact/relationship _____ Phone_____

The following questions are optional, answers are confidential and may be helpful to serve you best.

Domestic status (circle) single partnered married Children's years of birth_____

Occupation(s)_____

Other activities/interests/hobbies _____

Exercise and stress-reduction activities w/frequency_____

Religious, spiritual, or philosophic practices _____

"Recreational" drugs inc. tobacco and alcohol w/frequency_____

Therapy or support group experience, purpose and dates _____

_____

Previous bodywork, massage, PT, DC, etc._____

_____

Areas of current discomfort_____

Areas of occasional discomfort _____

Goals for these sessions _____

_____

Other (areas to be massaged or not, sensitive areas, depth of touch preferred)_____

_____

Please read and sign the statement below.

I understand that these services are offered as a health aid and supplement only and in no way take the place of diagnosis and treatment by a licensed health care provider. Any information and opinions offered here will be taken and acted upon at my own discretion and responsibility. I agree to communicate with the practitioner immediately if I want something different or if my well-being is adversely affected in any way. I have read or will read "Session Policies and Guidelines" and agree to those terms or will ask to negotiate other terms in advance.

Date_____Signature_____