STACY BULLOCK, LICENSED MASSAGE THERAPIST

Confidential Client Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____ Referred by: _____

Previous Experience with Massage: _____

If you have had massage therapy before, how do you like your pressure? Circle one

Light Medium / Firm Deep

Primary Reason for Today's Visit: _____

Areas of Tension or Pain: _____

Please list any surgeries, accidents, or injuries and when they occurred: _____

_____

Areas of Limited Movement: _____

_____

Areas you are Ticklish or Sensitive to Pressure: _____

Areas you do NOT want touched: _____

Physician / Health Care Professional: _____

Current Medications (including herbs, vitamins, etc): _____

_____

Please mark an "X" for all current conditions below. Please mark a "P" for all past conditions.

_____ Acute / Chronic Pain
_____ Headache / Migraines
_____ Joint / Muscle Pain
_____ Diabetes / Hypoglycemia
_____ Neck / Spine Disorders
_____ High or Low Blood Pressure (circle one)
_____ Numbness / Tingling
_____ P.M.S. Syndrome
_____ Asthma / Lung Conditions
_____ Osteoporosis
_____ Sleeplessness

_____ Digestive Problems
_____ T.M.J. Syndrome
_____ Heart / Blood Conditions
_____ Skin Conditions / Athlete's Foot
_____ Carpal Tunnel Syndrome
_____ Cancer / Tumors
_____ Varicose Veins
_____ Arthritis
_____ Emotional Changes
_____ Flu / Cold / Infections
_____ Allergies

For women, are you pregnant? Yes No If yes, how many weeks? _____

Other medical conditions not listed: _____

How much water do you drink each day? _____

How often do you exercise / stretch? _____

Who referred you to me? _____

Finally, Favorite Restaurant or Store*: _____
***I like to reward returning clients with the occasional gift card.**

Legal Disclaimer: I understand if I experience any pain or discomfort during my session(s), I will immediately inform the therapist so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork is not to be used as substitute for medical examination, diagnosis, or treatment by a physician. I acknowledge that if I have any mental or physical condition, I should see the appropriate qualified health care professional (physician, psychologist, etc.) Because massage should not be done under certain medical conditions, I affirm I have stated all my known medical conditions and answered all questions truthfully. I agree to keep the therapist updated as to changes in my medical conditions, and understand that there shall be no liability on the therapist's part should I forget to do so.

Client Name: _____

Client Signature: _____