

W e l c o m e

Client Information

First name	<input type="text"/>	Middle	<input type="text"/>	Last Name	<input type="text"/>
Gender	<input type="checkbox"/> F <input type="checkbox"/> M	Date of birth	<input type="text"/>		
Address	<input type="text"/>				
City	<input type="text"/>	State	<input type="text"/>	Zip	<input type="text"/>
Home Ph.	<input type="text"/>	Cell Ph.	<input type="text"/>	Work Ph.	<input type="text"/>
Email	<input type="text"/>			Add to mailing list?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/School name	<input type="text"/>				
Occupation	<input type="text"/>				
How did you hear about us?	<input type="text"/>				
Have you had massage/bodywork before?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Emergency Contact

First & Last Name	<input type="text"/>	Relationship	<input type="text"/>
Home Ph.	<input type="text"/>	Work Ph.	<input type="text"/>
		Cell Ph.	<input type="text"/>

Patient Personal Health History

What results would you like to receive from massage?

Current diagnosed conditions:

Past Significant Health Problems (injuries, surgeries, accidents, etc)

List known allergies:

What medications are you currently taking and for which conditions?(attach a separate sheet if necessary)

Are you taking aspirin, warfarin (Coumadin) or heparin-containing medications? Yes No

