

CLIENT HISTORY RECORD

Welcome and thank you for choosing our massage therapy services.
All of the following information will be kept strictly confidential.

Date of Visit: _____ Address: _____
Name: _____
Phone: _____
Email: _____ Birthdate: _____
Occupation: _____ Referred By: _____

Have you ever had massage therapy before? Yes ___ No ___
How Often? _____

What are your favourite leisure activities? _____

Stress Level: High Medium Low
Skin Type: Normal Oily Dry
Diet: Do you eat: Vegetables Fruits Whole Grains
 Processed Foods Junk Food Meats

HEALTH HISTORY

Are you currently under the care of a: Doctor _____ Naturopath _____
Chiropractor _____ Physiotherapist _____
Medications you are presently taking _____
Any Allergies? Please list _____

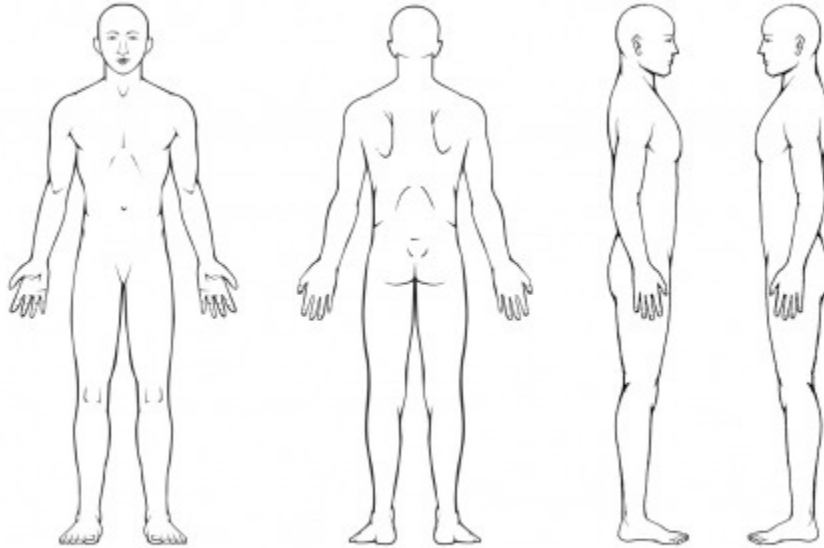
Please mark C for current, P for past if you have had the following:

___ Heart/Circulation	___ Auto Accident	___ Hormonal Problems
___ Arthritis/Bursitis	___ Headaches/Migraines	___ Menstrual Cramps
___ Sleep Disorders	___ Sports/Work Injuries	___ Fibromyalgia
___ Cancer	___ Skin Conditions	___ Digestive/Intestinal
Type _____	(psoriasis, warts, etc)	Disorders
___ Diabetes	___ Smoke	___ Stress
___ Respiratory Disorders	___ Blood pressure	___ Nervous Disease
(asthma/lung)	low or high	(Epilepsy)
___ Dizziness	___ Surgeries	___ Numbness
___ Kidney/Bladder	___ Osteoporosis	___ Pregnant ___ weeks
___ HIV	___ Hepatitis	

Are there any other physical or emotional conditions you feel I should be aware of: _____.

To enhance the effects of your massage and avoid soreness, drink water and take a warm bath with 2 cups of Epsom salts after treatment

Please indicate the sites of pain, stiffness or lack of flexibility on the diagrams



I _____ hereby release Casa Massage & Holistic Wellness Inc. all liability from problems arising from receiving any of the therapies and services as a result of information not given or incorrectly given in this record.

Signature of Client/Guardian

Signature of Therapist

CLINICAL NOTES: