# CLIENT CONSULTATION FORM

Name _____ Date_____
First Middle Initial Last

Address_____

City/State/Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____

Email_____

Emergency Contact _____Phone (_____)_____

Referred by _____Reason for appointment_____

**General & Medical Information**

Occupation _____ DOB _____ Male Female

Physician _____ Phone (_____)_____

Have you ever received a massage/facial/waxing? Yes If yes, how recently?_____ No

What type of pressure do you prefer? Light Medium Firm Deep Tissue

Please take a moment to carefully read the following information and check mark as indicated. If you have a specific medical condition or specific symptoms, a service may be contraindicated and not advised. If you check mark any of the conditions, please explain as clearly as possible below.

___ Allergies
___ Aneurysm
___ Arthritis: Osteo, RA, AS, etc.
___ Athlete's foot
___ Back/neck pain
___ Blood pressure = high or low
___ Bruises/burns
___ Cancer Where:_____
___ Cardiac/Heart condition
___ Circulatory issues
___ Contact lenses
___ Contagious diseases
___ C.O.P.D.
___ Dentures
___ Diabetes
___ Epilepsy or seizures
___ Fibromyalgia
___ Headaches/Migraines
___ Hemophilia
___ Injuries/Broken bones
___ Joint swelling/dysfunction
___ Kidney stones
___ Leukemia
___ Numbness/tingling
___ Osteoporosis
___ Pregnant/Lactating
___ Stress/anxiety
___TMJ syndrome
___Varicose veins
Accidents or injuries in past year?_____
_____
_____

Explanation of any check marks above:_____

_____

_____

_____

Do you have any other conditions not listed above?_____

_____

_____

_____

Are you taking any medications I should know about and have you taken them today? Please explain.

_____

_____

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