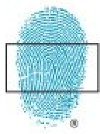


mti physical therapy
PROVIDING ONE-TO-ONE CARE

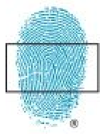
Client Information Form - Massage Therapy

Name: ____ Birth Date: _____________
Address: ______________________________ City ______________ State _____ Zip _________
Preferred Contact Method: **o** (Cell) _______________ **o** (E-mail) ____________________
Occupation: ____
Referred by: ____
Emergency contact person: _____________________________ Phone: __________________

oYes o No Have you previously experienced bodywork? What kind?________________
oYes o No Are you currently under a physician's care for any condition? Please describe: _______
____
Physician's name: ________________________ Phone: _____________ Fax:______________
Primary reason for today's visit, (please explain):______________________________
____
Areas of complaint, pain, tension, (please explain): ____________________________
____

Please answer the following questions:

o Yes o No Do you wear contact lenses?
o Yes o No Do you wear dentures?
o Yes o No Do you have any allergies? Please describe, especially if regarding a specific essential oil or lotion: ____
o Yes o No Do you have arthritis? What type and where? Please describe: ______________
____
o Yes o No Do you have any heart problems? Please describe: ____________________
____
o Yes o No Do you have any spinal problems? Please describe: ____________________
____
o Yes o No Are you presently pregnant? How far along? Complications? _______________
____
o Yes o No Do you have varicose veins or blood clots? Please indicate where:____________
____
o Yes o No Do you have any skin problems, diseases, or open sores? Where?____________
____
o Yes o No Have you had surgery? How recently? Complications? ___________________
____
o Yes o No Do you take any prescribed medications? Please list: ___________________
____
o Yes o No Do you take supplements, herbs, and/or vitamins? What kind? ______________
____
o Yes o No Do you exercise or play sports on a regular basis? Please describe: __________
____



Client Information Form - Massage Therapy

o Yes o No Are you receiving any other complementary care currently, (chiropractor, naturopathic, acupuncture, nutritional, herbal, homeopathic, hypnotherapy)? If so, please describe:____________________
____

o Yes o No Do you have any other physical or mental condition of which I should be aware before giving you a massage therapy treatment? If yes, please describe:____
____

Please read and initial:

____ I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation and energy flow.

____ I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. In addition, the massage therapist does not prescribe medical treatment or pharmaceuticals.

____ It is understood that any illicit or sexually suggestive remarks or advances on the client's part will result in immediate termination of the massage session, and the client will be liable for payment of the full scheduled appointment.

____ I understand that massage therapy is not a substitute for medical examinations and/ or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

____ Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions

Signature: ____ Date: _____________

I have completed the above information accurately and have read, understand, and take responsibility for the above statements.

Therapist Notes: