Motus Massage Therapy
Client Information Form

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (work) _____ Phone (home) _____

Date of Birth _____ Primary Physician _____

Occupation _____ Employer _____

Email Address _____ Send Me Special Offers? YES NO

How were you referred to us? _____

Primary reason for appointment _____

Areas of complaint, pain, or tension _____

Please answer the following questions by circling "YES" or "NO"

YES	NO	Have you ever had a professional massage?
YES	NO	Have you ever had surgery?
YES	NO	Do you wear contact lenses?
YES	NO	Do you have food allergies or sensitive skin condition(s)?
YES	NO	Are you currently taking any prescription medications?
YES	NO	Have you suffered any injuries recently?
YES	NO	Do you have varicose veins or blood clots?
YES	NO	Do you have arthritis?
YES	NO	Do you have any heart conditions?
YES	NO	Do you have high blood pressure?
YES	NO	Do you have any spinal issues?
YES	NO	Do you exercise regularly or participate in any sports?
YES	NO	Do you have any other medical conditions not previously noted which I should be aware of before giving you a massage? *

* I understand massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow.
* I understand the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor perform any spinal manipulations. It has been made very clear to me massage therapy is not a substitute for medical examination, diagnosis, and/or treatment.
* A massage therapist must be made aware of existing physical conditions and I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____ Date _____

Printed Name _____