

Full Circle Massage Therapy, Inc.
A Company for Your Health & Relaxation

Confidential Client Record Sheet

NAME: _____ HOME#: _____ CELL#: _____

WORK#: _____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ M / F (CIRCLE ONE) OCCUPATION: _____

REFERRED BY: _____ HAVE YOU EVER HAD A MASSAGE BEFORE? YES / NO

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? _____ DR'S NAME: _____

DATE OF LAST CHECKUP, PHYSICAL OR DR'S VISIT: _____

PLEASE LIST ANY MEDICATIONS or VITAMINS YOU ARE TAKING: _____

IF SO, FOR WHAT CONDITION: _____

CIRCLE ANY THAT APPLY TO YOU:

Headaches	Shoulder Pain	Poor Circulation	Sinusitis	Pregnancy *
Migraines	Arms/ Hands	Chronic Fatigue	Allergies	Fibromyalgia
Neck Aches	Feet/Leg Aches	PMS	High Blood Pressure	Diabetes
Backache	Arthritis	Depression	Orthodontics	HRT **

* see reverse side ** Hormone Replacement Therapy

Varicose Veins	Thrombosis	Phlebitis	Skin Rashes	Scabies
Numbness	Osteoporosis	Seizure Disorder	Strokes	Poison Ivy
Inflammation	Sunburn	Open Cuts	Burns	Severe Pain

Have you ever had any serious accident or injury? (please list) _____

(continued on other side)

Please rate your use of the following: (None, Light, Moderate, or Heavy)

Exercise _____ Alcohol _____ Tobacco _____ Water _____ Caffeine _____

Do you consider your job stressful? _____ How many hours a week do you work? _____
Do you enjoy your job? _____ What do you spend the majority of the day doing? _____

Do you consider your personal life stressful? _____ Are you: **Married Widowed Divorced Single**
Do you have children? _____ How many and what ages? _____
Are you a physical caretaker for a family member? _____

Do you sleep well at night? _____ How many hours? _____
What position do you sleep in? **Side Back Stomach** Do you use pillows for support? _____

How much time do you set aside for yourself? _____ Do you have any hobbies? _____
When was the last time you had a good laugh? _____
Overall are you satisfied with your life? _____
How do you hope to benefit from massage therapy? _____

Pregnancy

Care Giver/Doctor's Name _____ How many weeks? _____

Are you having any complications or have you had any complications with past pregnancy? _____

Are you experiencing any discomfort during this pregnancy? Please describe _____

1st Visit Date: (for therapist use only) _____ _____ _____

I UNDERSTAND THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL OR CHIROPRACTIC CARE AND THAT THE THERAPIST DO NOT DIAGNOSE MEDICAL CONDITIONS. I AFFIRM THAT IT IS SAFE FOR ME TO RECEIVE MASSAGE THERAPY. **CANCELLATION POLICY:** I UNDERSATND THAT I AM EXPECTED TO GIVE A 24 HOUR NOTICE FOR CANCELLATIONS. I FUTHER UNDERSTAND THAT PAYMENT IS EXPECTED FOR THE TIME THAT I HAVE RESERVED IN THE EVENT OF LATE CANCELLATION OR MISSED APPOINTMENTS, UNLESS OTHER ARRANGEMENTS ARE MADE.

SIGNATURE: _____ DATE: _____

Emergency Contact: _____ **Number:** _____

Would you like to be on our mailing list? YES _____ NO _____