



Therapeutic Touch of Health  
Client Information Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Birth date: \_\_\_\_\_  
Contact Phone Number (s): \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Current Hobbies: \_\_\_\_\_  
Primary Reason for Visit: \_\_\_\_\_  
\_\_\_\_\_

Medical Information:

Please check the medical condition(s) that apply to you:

- |  |   |
|--|---|
| <input type="checkbox"/> Accident injury | <input type="checkbox"/> Heart condition      |
| <input type="checkbox"/> Acute pain      | <input type="checkbox"/> Infectious condition |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> High blood pressure  |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Chronic pain    | <input type="checkbox"/> Skin Condition       |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Varicose veins       |

Other: \_\_\_\_\_

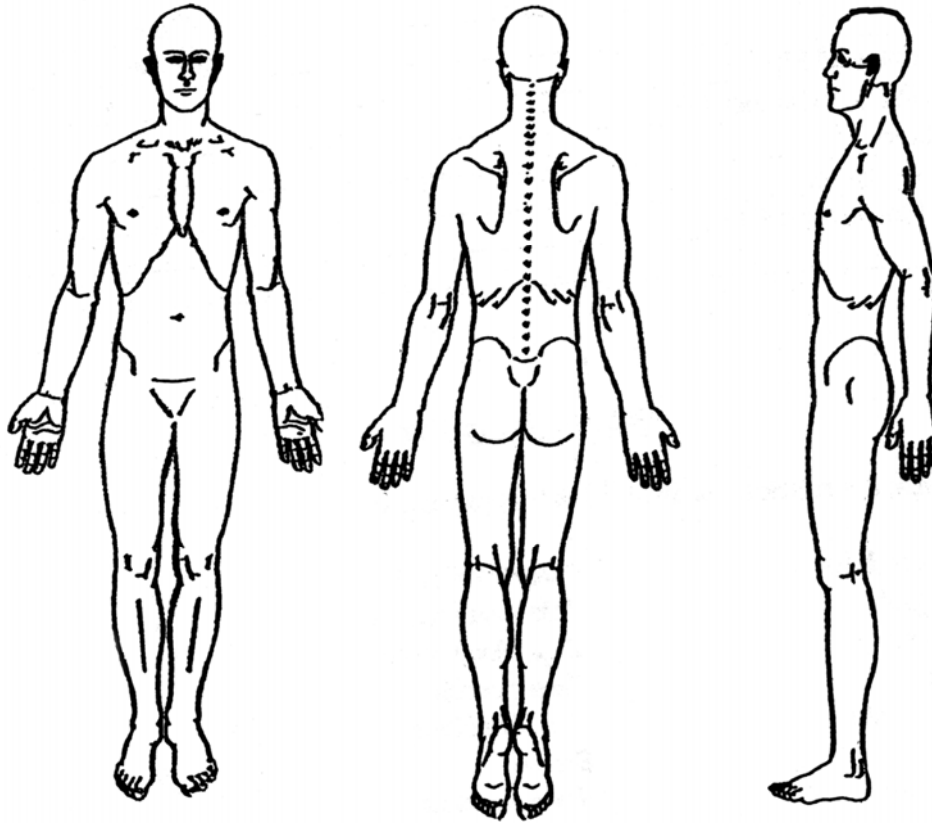
Previous surgery includes: \_\_\_\_\_

Are you currently under the care of a health professional? \_\_\_\_\_

If yes, Doctor's Name \_\_\_\_\_

Doctor's Phone No. \_\_\_\_\_

Current Medication(s) \_\_\_\_\_



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Name: \_\_\_\_\_

I understand that the massage I receive is provided for the basic purpose of preventive maintenance (relaxation, stress reduction, relief of muscular tension). If I experience any pain or discomfort during the session, I will inform the therapist so that the pressure or strokes may be adjusted to my level of comfort.

I understand that massage should not be construed as a substitute for medical exam, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any medical condition I am aware of.

Because massage is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Therapist: \_\_\_\_\_ Date: \_\_\_\_\_