THERAPEUTIC MASSAGE & NUTRITIONAL CENTER

NEW CLIENT INFORMATION FORM

Please print clearly:

Name____ Date _______________

Address ____ Apt.# _____________

City ______________________________ State ____________ ZIP _______________

Shipping Address: _____________________________ Home Phone (____) ____-______

____ Work Phone (____) ____-______

e-mail address: ____

REFERRED BY: ____

Occupation ____________________ Employer ___________________________________

Date of Birth __________________ Age ____ Sex: M / F Height ______ Weight ______

Emergency Contact: ______________________ Emerg. Contact's Phone (____) ____-_____

Marital Status: S M D W Name of Spouse_______________________________

Describe health of spouse: ________________________ Number of children if any ______

Name of Child	Age	Sex	Any physical conditions or concerns?
_________________________	____	M/F	_________________________________
_________________________	____	M/F	_________________________________
_________________________	____	M/F	_________________________________

Family history of serious illnesses (circle those which apply):

Cancer / Diabetes / Heart / Other____

Any household pets or other animals you or family members are in close contact with:

____

HISTORY:

Overall health (circle one): Excellent / Good / Fair / Poor / Other: ___________________

Chief complaint (reason you are here): (use separate sheet if more room needed)

____

Previous treatments for this complaint ______________________________________

____

Other complaints or problems: (use separate sheet if needed) ____________________

____

HISTORY (continued):

Current medications/drugs being taken: (use separate sheet if needed) _______________

____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: ____________________

Chief complaint (reason you are here): (use separate sheet if more room needed)

____

Previous treatments for this complaint ____

____

Other complaints or problems: (use separate sheet if needed) ______________________

____

Current medications/drugs being taken: (use separate sheet if needed) _______________

____

List any major illnesses (with approx. dates):_______________________________________

____

____

List any surgery or operations with approx. date: ___________________________________

____

Past Accidents or injuries:____

____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):
Name____ Date ________

Nutritional supplements you are taking: ____

Allergies (drugs, food, other) ____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)
Cigarettes _______________ Coffee __________________ Alcohol _________________

Other information: ____

Please mark the conditions that apply to your **personal health history**:

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ Blood Clotting
- ☐ Circulatory Disorders
- ☐ Stroke
- ☐ Skin Condition
- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Epilepsy/Seizures
- ☐ Multiple Sclerosis
- ☐ Pregnant
- ☐ Osteopenia/Osteoporosis
- ☐ Scoliosis
- ☐ Migraine Headaches
- ☐ TMJ Dysfunction
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Mild/Low Back Pain
- ☐ Sciatica
- ☐ Hip & Knee Pain
- ☐ Bulging Disc
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Carpal Tunnel Syndrome
- ☐ Thoracic Outlet Syndrome
- ☐ Fever (last 24 hours)
- ☐ Communicable Disease
- ☐ HIV Virus
- ☐ Hospitalization
  Dates: ___________
- ☐ Injury
  Dates: _________
- ☐ Other ________________
- ☐ Other ______________

OFFICE POLICIES:

_____ (initial**) Payment Policy**: I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made in advance, I agree to pay for each session at the time of the session. I also agree to the $20 return check charge in the event that my check is returned.

_____ (initial) **Cancellation Policy**: I understand that any appointment NOT cancelled more than 24 hours prior to the scheduled time will be billed $40. There will be one "grace" given for a missed or late-cancelled appointment.

_____ (initial) The information I have provided is truthful & complete to the best of my knowledge. I assume responsibility for advising the clinician of any changes in my condition. Should I experience pain or discomfort during massage, or adverse response to nutrition, I will immediately inform the clinician.

_____ (initial) I understand that the Therapeutic Massage & Nutrition Center **does NOT diagnose** medical disease/condition, nor prescribe; it is **NOT a substitute for physician diagnosis and treatment.**

_____ (Initial) This is a *Therapeutic* Clinical Practice OFFICE. We reserve the right to refuse service.

Appointment Reminders: Permission for a voicemail? Yes / No For a text? Yes / No

Client Signature: ____ DATE ________________

Office Use Only: