Body Therapy Center Student Massage Clinic
Confidential Client Information Form

Patient Information

Name:	Today's Date:
Address:	City, State, Zip:
Home Phone:	Work/Cell Phone:
Occupation:	Date of Birth:
Emergency Contact:	Emergency Contact Phone:
Would you like to be on our emailing list? □ Yes □ No	If yes, list your email address:

Are you currently under a physician's care for an acute or chronic illness? □ Yes □ No
If yes, please explain:_____
Are you currently taking any prescribed medication/supplement? □ Yes □ No
If yes, please explain:_____
Are you currently experiencing stress in your work or personal life? □ Yes □ No
If yes, please explain:_____
Have there been any significant changes in your life recently? □ Yes □ No
If yes, please explain:_____

Have you consumed alcohol in the last 24 hours? □ Yes □ No
Do you have a fever? □ Yes □ No

Are you under 18 years of age? □ Yes □ No
If yes, parental consent must be obtained on this form prior to session.
Are you pregnant or think you may be pregnant? □ Yes □ No
If yes, what trimester_____ and your due date_____
Have you had surgery or been involved in an accident in the last 24 months? □ Yes □ No
If yes, please list:_____

Session Information

Have you had a massage before? □ Yes □ No
If yes, when:_____

What are your goals for this session?_____

What type of touch do you prefer?
□ Light/Meditative □ Heavy/Invigorating □ Deep/Trigger Point

Do you have difficulty lying on your front, back, or side? □ Yes □ No
If yes, please explain:_____

Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin? □ Yes □ No
If yes, please explain:_____

Please list areas of tension, stress, and/or pain you wished to be addressed:_____
_____

Please list any area(s) you DO NOT want the therapist to massage: _____
_____

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal
- o Headaches
- o Joint stiffness/swelling
- o Spasms/cramps
- o Broken/fractured bones
- o Strains/sprains
- o Back, hip pain
- o Shoulder, neck, arm, hand pain
- o Leg, foot pain
- o Chest, ribs, abdominal pain
- o Problems walking
- o Jaw pain/TMJ
- o Tendinitis
- o Bursitis
- o Arthritis
- o Osteoporosis
- o Scoliosis
- o Bone or joint disease
- o Other: _____

Circulatory and Respiratory
- o Dizziness
- o Shortness of breath
- o Fainting
- o Cold feet or hands
- o Cold sweats
- o Swollen ankles
- o Pressure sores
- o Varicose veins
- o Blood clots
- o Stroke
- o Heart condition
- o Allergies
- o Sinus problems
- o Asthma
- o High blood pressure
- o Low blood pressure
- o Lymphedema
- o Other: _____

Skin
- o Rashes
- o Allergies
- o Athlete's Foot
- o Warts
- o Moles
- o Acne
- o Cosmetic surgery
- o Other: _____

Digestive
- o Nervous stomach
- o Indigestion
- o Constipation
- o Intestinal gas/bloating
- o Diarrhea
- o Diverticulitis
- o Irritable bowel syndrome
- o Crohn's Disease
- o Colitis
- o Other: _____

Nervous System
- o Numbness/tingling
- o Twitching of face
- o Fatigue
- o Chronic pain
- o Sleep disorders
- o Ulcers
- o Paralysis
- o Herpes/shingles
- o Cerebral Palsy
- o Epilepsy
- o Chronic Fatigue Syndrome
- o Multiple Sclerosis
- o Muscular Dystrophy
- o Parkinson's disease
- o Spinal cord injury
- o Other: _____

Reproductive System
- o PMS
- o Menopause
- o Pelvic Inflammatory Disease
- o Endometriosis
- o Hysterectomy
- o Fertility concerns
- o Prostate problems

Other
- o Loss of appetite
- o Forgetfulness
- o Confusion
- o Depression
- o Difficulty concentrating
- o Drug use _____
- o Alcohol use _____
- o Nicotine use _____
- o Caffeine use _____
- o Hearing impaired
- o Visually impaired
- o Bladder infection
- o Eating disorder
- o Diabetes
- o HIV/AIDS
- o Fibromyalgia
- o Post/Polio Syndrome
- o Cancer
- o Physical/Emotional Abuse
- o Other congenital or acquired disabilities (please list) _____ _____
- o Infectious disease (please list) _____
- o Other: _____

For clients who need mobility assistance, please give your height: _____ weight: _____

Please list any additional comments regarding your health and well-being: _____ _____

CONSENT TO PARTICIPATE IN STUDENT MASSAGE: I understand that the student massage clinic exists to provide hands-on training for massage students of The Body Therapy Center School of Massage, Ltd., and that I have been fully informed that my participation is voluntary. I have no medical or health conditions which would preclude my participation; that student massage services are limited in accordance with the school curriculum and not intended to diagnose illness, disease or any other medical or health disorder; that student massage is not a substitute for an evaluation or a massage from a licensed certified massage therapist; that I agree to resolve any dispute through arbitration with the American Arbitration Association as my sole legal remedy; that I agree to hold harmless The Body Therapy Center School of Massage, Ltd., its officers, students, staff or affiliates from any injury arising from my participation in the student massage clinic and that I have read and fully understand the terms and conditions of the CONSENT TO PARTICIPATE IN STUDENT MASSAGE and I consent to participate. I understand a clinic supervisor is on-duty and I will direct any questions or concerns to that supervisor.

Client's Signature:_____ Date:_____

Parent / or Guardian Signature_____ Date:_____