

Date			
Date			

Client Registration and Health Information

Name	Date of Birth_		Age	
Address	City	State	Zip	
Home Phone	Cell Phone			
Emergency Contact	Phone			
Email	Occupation			
Physician name	Phone			
Referred by	Have you had	a massage before? _		
If so, for what?	Type of massa	nge?		
Check all that apply, past or present.				
HospitalizationSurgeries/Acci	identsHerniated/Rupt	cured discScoli	osisBursitis	
Infectious DiseaseHigh Blood	PressureBlood clots	Varicose Vein	sDiabetes	
Currently PregnantCancer/	TumorsHeadaches/	MigrainesCh	nronic Illness	
Pain:BackLow BackNec	ckShoulderArm	LegOther_		
Allergies:				
Other pertinent health information:				
Current Medications:				
I understand this massage, Reiki, cupping of from muscle pain or spasm, and for increas diagnose illness or prescribe medical/pharmedical examination and it is recommend conditions or concerns I might have.	sing circulation. I further undo maceutical treatment. This so ded that I contact a licensed	erstand that licensed r ession or others to fol I health care provider	massage practitioners do not low are not a substitute for r for any medical or health	
I understand that I am financial responsible charge. Cancellations made between 24 a notice of cancellation will incur a 100% char	and 6 hours prior to an appoi	ntment will incur a 50	% charge. Less than 6 hou	
Date 5		nature of client or guardian if under 18 years of age		