HANDS ON WELLNESS CLIENT INFORMATION

Name _____ Birthdate _____
Address _____
_____
Phone_____ Occupation _____
Email_____
Emergency Contact _____ Phone _____
Whom may I thank for referring you?_____

HEALTH AND MEDICAL INFORMATION

Do you, or have you suffered with any of the following

___High Blood Pressure	___Osteoporosis	___Low Back Pain
___Low Blood Pressure	___Bursitis	___Arthritis
___Blood Clots	___Broken Bones	___Skin Infection/Rash
___Varicose Veins	___Muscle Strains	___Stroke
___Pregnant	___Muscle Sprains	___Diabetes
___Headaches	___Allergies(skin)	___Hayfever
___Allergies(food)	___Sleep Issues	___Stress

Explain any of the above _____
_____

Are you taking any medication?	Y/N
Do you bruise easily?	Y/N
Do you suffer from epilepsy or seizures?	Y/N
Do you have cardiac or circulatory problems?	Y/N
Do you experience muscle tightness/cramping?	Y/N
Do you experience Sciatica, or disc issues?	Y/N
Do you experience dizziness or fainting spells?	Y/N

Have you had a professional massage or body work before? When?
_____

Are they any areas you would like me to focus on today?
_____
Are there any areas you would like me to avoid today? _____

Sign _____ Date_____