Skin Deep
Rejuvenation Clinic

CONFIDENTIAL CLIENT INFORMATION

ALLERGIES_____

Name_____

Address:_____

City: _____ State: _____ Post Code: _____

Telephone (H): _____ (W) _____

(M) _____ (email)_____

DOB: _____ Height: _____ Weight _____

Physician: _____ Ph: _____ Medication: _____

Occupation: _____ Employer: _____ How did you hear about us? _____

If Friend their name: _____

Primary reason for appointment:

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE APPROPRIATE ANSWER.

Have you had a professional massage?	Yes/No	Are you pregnant?	Yes/No
Have you ever had surgery?	Yes/No	Have you ever had Cancer?	Yes/No
Do you have any back problems?	Yes/No	Do you suffer from tension?	Yes/No
Do you suffer headaches?	Yes/No	Do you suffer with heart problems?	Yes/No
Do you suffer with Blood Pressure?	Yes/No	Do you have Varicose Veins?	Yes/No
Have you ever suffered with blood clots?	Yes/No	Do you suffer with constipation	Yes/No
Do you suffer with diarrhoea?	Yes/No	Do you have arthritis?	Yes/No
Are you constantly tired?	Yes/No	Have you suffered an acute injury?	Yes/No

Please explain your Yes answers:

Do you have any medical conditions I should be aware of? Please specify:

Do you have private health insurance coverage and with whom>

I _____understand that the massage therapy given here is for the purpose of stress reduction, relief for muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As, such the massage therapist prescribes neither medical treatment, nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature: _____ **Date:** _____