

JEREMY HALL, LMT // CLIENT INFORMATION

NAME _____ **PHONE** _____

ADDRESS _____ **CITY** _____ **STATE** _____

DOB __/__/__ **AGE** ___ **M**__ **F**__ **OCCUPATION** _____

HAVE YOU EVER HAD A MASSAGE? YES NO
IF SO, WHAT DID YOU LIKE BEST?

ARE YOU TAKING ANY MEDICATIONS? YES NO
IF SO, WHAT?

PLEASE CHECK ANY THAT APPLY:

- | | |
|--|--|
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> SPRIANS |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> SHOULDER PAIN | <input type="checkbox"/> SCOLIOSIS |
| <input type="checkbox"/> BACK PAIN | <input type="checkbox"/> FIBROMYALGIA |
| <input type="checkbox"/> SCIATICA | <input type="checkbox"/> CARPAL TUNNEL |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> JOINT PAIN |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HIV |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ALLERGIES? |

IF YES TO ALLERGIES, PLEASE LIST:

WHAT ARE YOUR EXPECTATIONS FOR THIS TEHRAPY SESSION?

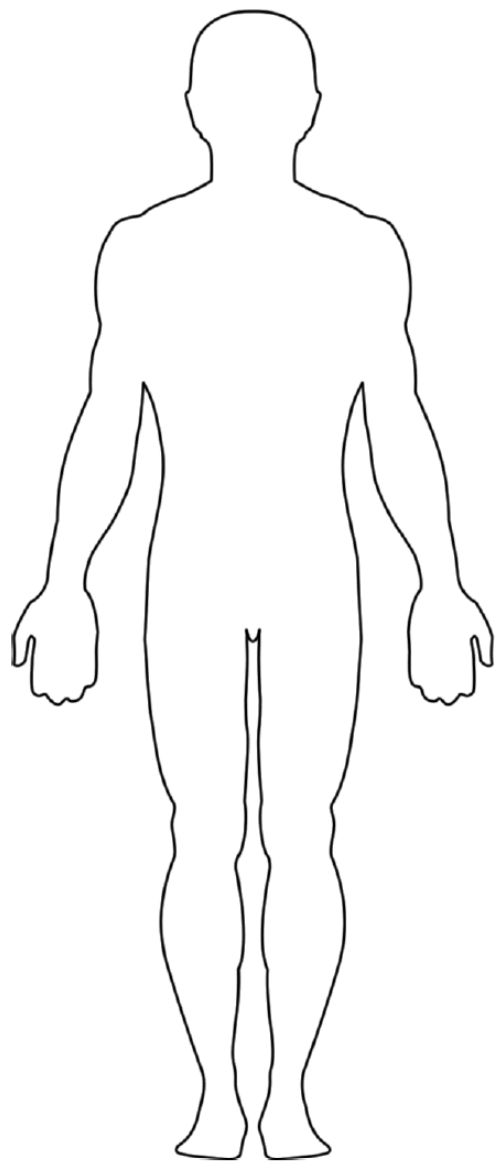
**I acknowledge that this therapy session is not intended for
replacement of medical care.**

Patient Signature

Date

BODY PAIN INDICATOR CHART
Please indicate with an "X" the areas of pain.

Front



Back

