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:

__ NECK PAIN
__ HEADACHES
__ SHOULDER PAIN
__ BACK PAIN
__ SCIATICA
__ ARTHRITIS
__ CANCER
__ DIABETES
__ SPRIANS
__ SEIZURES
__ SCOLIOSIS
__ FIBROMYALGIA
__ CARPAL TUNNEL
__ JOINT PAIN
__ HIV
__ 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.