

CLIENT INFORMATION FORM

ALEXANDER COLLINS, L.M.T.

Please complete the following client information form. Save & Email to ACollins.Massage@gmail.com

Name:

Address:

City: State: Zip:

Phone: May I text you appointment info? Yes No

Email: May I email you appointment info? Yes No

Date of Birth: Anniversary: Occupation:

Referred by: Website Facebook Friend/Family:

Other:

How often do you receive massage therapy?

How often would you like to receive massage therapy?

General Stress Level (1=Low, 10=High) Desired Pressure (1=Light, 5=Firm, 10=Deep)

Please check the following conditions that apply to you:

<input type="checkbox"/> Headache	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stroke	<input type="checkbox"/> Skin problems: Acne
<input type="checkbox"/> Back problems (explain below)	<input type="checkbox"/> Seizures	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Skin problems: Athlete's Foot
<input type="checkbox"/> Neck problems (explain below)	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Skin problems: Open sore or cut
<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Siatica	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Bruise easily
<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Hormonal imbalances	<input type="checkbox"/> Cancer, Type: <input type="text"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tumors	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Elimination problems
<input type="checkbox"/> Blood clots	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> TMJ	<input type="checkbox"/> Digestion problems
<input type="checkbox"/> Cyst	<input type="checkbox"/> Hepatitis C		<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Insomnia		<input type="checkbox"/> Skin Allergies (explain below)
<input type="checkbox"/> Water Retention	<input type="checkbox"/> Menstrual cramps		<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart problems			<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Contact Lenses			<input type="checkbox"/> High Blood Sugar
<input type="checkbox"/> Hearing Aids			<input type="checkbox"/> Low Blood Sugar
<input type="checkbox"/> Other: <input type="text"/>			<input type="checkbox"/> Currently Pregnant:
			<input type="text"/> weeks, Due Date: <input type="text"/>

Please expand on any of the above:

Medications (please list):

Surgeries (please list):

Do you currently exercise? Yes No If yes, please list type and how often:

By checking this box, the client acknowledges that he/she has read this agreement, and listed any conditions Alexander Collins, LMT should be aware of.

**If you enjoy your massage therapy experience, please tell all your friends.
For every referral you will receive \$25 off your next massage therapy appointment.**