



# Ronda Korzon | *Massage Therapy*

## CLIENT INFORMATION FORM



Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Telephone \_\_\_\_\_ E-mail \_\_\_\_\_  
Home Cell

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs

Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Reason for seeking massage therapy: \_\_\_\_\_

Have you received massage before?  yes  no If yes, how long since your last massage? \_\_\_\_\_

Types of massage you've experienced \_\_\_\_\_

Please indicate the areas of complaint by marking them on the figure to the right:

Check all that apply to those areas:

Sensation:  Pain  Tingling  Numbness

Level:  Mild  Moderate  Severe

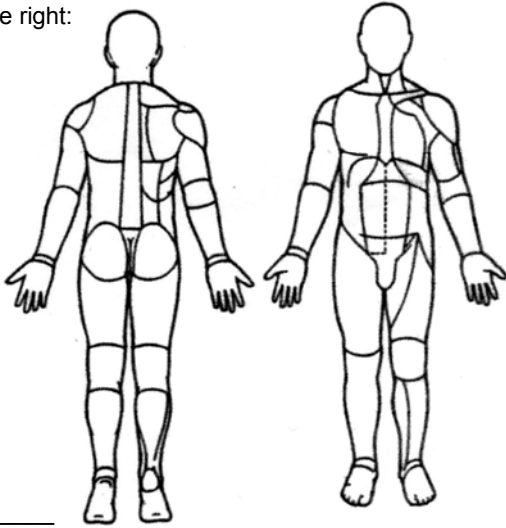
Frequency:  Constant  Intermittent

Status:  Improving  Getting worse  No change

Does this effect your: Sleep  yes  no Work  yes  no

Does this effect your daily activities:  yes  no

If yes, please list: \_\_\_\_\_



Are you currently receiving medical treatment?  yes  no

If yes, for what condition? \_\_\_\_\_

Are you pregnant?  yes  no If yes, the due date is: \_\_\_\_\_

Current Medications: Prescriptions \_\_\_\_\_

Over the counter \_\_\_\_\_

Health Care Provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Health Information:** Please indicate if you have or have had conditions affecting the following systems of the body.

Check and/or give details of the condition.

Current    Past

- SKIN (e.g., rashes, warts, contagious infections) \_\_\_\_\_
- SKELETAL (e.g., osteoporosis, arthritis, scoliosis, spinal/disk problems) \_\_\_\_\_  
\_\_\_\_\_
- CIRCULATORY (e.g., blood clots, high/low blood pressure, varicose veins, heart problems) \_\_\_\_\_  
\_\_\_\_\_
- ENDOCRINE (e.g., diabetes, hyper/hypo thyroid) \_\_\_\_\_
- RESPIRATORY (e.g. allergies, asthma, bronchitis) \_\_\_\_\_
- DIGESTIVE (e.g. gastric reflux, bowel dysfunction, auto-immune disease) \_\_\_\_\_
- URINARY (e.g., kidney dysfunction, bladder problems) \_\_\_\_\_

**Major Illness/Surgeries/Accidents:** Please list and provide information on any you have had.

Illness/Surgery/Accident \_\_\_\_\_ Date \_\_\_\_\_

Illness/Surgery/Accident \_\_\_\_\_ Date \_\_\_\_\_

**Exercise:** Please identify the exercise activities you engage in - duration and frequency.

Activity \_\_\_\_\_ Duration \_\_\_\_\_ mins    Frequency \_\_\_\_\_ x per week

Activity \_\_\_\_\_ Duration \_\_\_\_\_ mins    Frequency \_\_\_\_\_ x per week

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### Consent for Care

I understand that massage therapy is for general relaxation, stress reduction , relief from muscular tension and improvement of circulation. I have stated all of my known medical information and understand that it is my responsibility to keep my massage practitioner informed of any changes in my health and of any medications I may take in the future. I also understand that a massage is not a substitute for medical treatment and that I should see a doctor/health care provider for diagnosis and treatment for any suspected medical problem.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent/guardian (if a minor) \_\_\_\_\_ Date \_\_\_\_\_