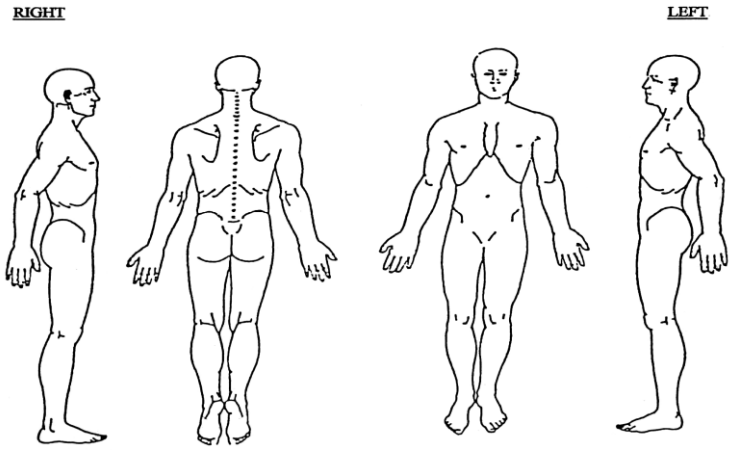
Confidential Client Information

Name _____ Date _____
Address _____ Referred by _____
City _____ Birth Date _____
Zip _____ Home Phone #_____
Employer_____ Cell Phone # _____
Occupation _____ Emergency Phone # _____
Work Phone # _____ Email _____

Exercise frequency: __Regularly __Sometimes __Never
Stretching frequency: _____
Activities: _____
Special Diet: _____
All allergies: _____

__contact lenses __eyeglasses __dental appliance __pregnant-due_____
__orthopedic device in shoe __hearing aid __pacemaker __breast implants

Areas that require attention during your massage session today:



Medications _____

_____

All medical conditions & year *(operations, accidents, broken bones, diseases, chronic pain, etc.)*

_____

_____

_____

_____

Are you currently under the care of a health care practitioner? Yes / No May we contact? Yes / No
Physician Name_____ Phone_____

Do you authorize sharing your therapeutic massage records with this medical practitioner? Yes / No

I understand that massage therapy given at Pam Darling Massage is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow. I made the massage therapist aware of all my existing physical conditions and agree to report any changes as they occur. Massage is contraindicated when experiencing any contagious conditions. I agree to have massage therapy and hold the therapist harmless for any problems that may arise as a result of the massage. I may be referred to another health practitioner for issues outside the scope of this massage therapist's practice.

Signature_____ Date_____