Therapeutic Massage by Leatha
1634 Avenue of the Cities
Moline, IL 61265
309-235-0263 cell phone

NEW CLIENT INFORMATION: Today's Date: _____

Client's Full Legal Name

_____ Sex: Male ___ Female ___
Last First Middle Initial

Date of Birth: _____ Age _____

Address: _____
Street City State Zip

Home Phone: ( )_____ Work Phone: ( ) _____

Cell Phone ( ) _____ email : _____

Status: (check one) Single: ___ Married: ___ Other: ___

Employment Status: (check one) Employed: ___ Retired: ___ Full-time student: ___

Employer's name: _____Type of work: _____

Family Physician_____ Physician Phone number _____

Reason for seeking massage therapy _____

Medical history

Have you had a massage before? _____

What are your goals for therapy? _____

Current medications:

Name of drug	Reason for taking it	Name of drug	Reason for taking it
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		Continue on back if needed	

Please list all surgeries: _____

Please check all that apply:

Hearing impairment		Parkinson's / Alzheimer's		Heart disease	
Headaches		Mental illness		High / low blood pressure	
Neck pain		Depression		Pacemaker	
Rib pain		Chronic pain		Fainting	
Back pain		Numbness / tingling		Dizziness	
Leg / foot pain		Stroke		Blood clots	
Arm / hand pain		Rashes / sores		Varicose veins	
TMJ / jaw pain		Skin sensitivities		Chronic coughing	
Broken bones		Athlete's foot		Lung disease, asthma	
Scoliosis (curve of spine)		Currently pregnant / trying		Shortness of breath	
Fibromyalgia		Urinary leakage		Sinus problem	
Bursitis		HIV / AIDS		TB	
Arthritis		Kidney disease		Allergies	
Osteoporosis		Cancer		Diabetes	
Lymphedema / swelling		Thyroid condition		Others, please list	

Social history:
Do exercise on a regular basis? What type? _____

Amount of stress(circle one):

At home	low	medium	high
At work	low	medium	high

Is there any other history you would like to tell me about?

Attendance policy:
Massage therapy at Therapeutic massage by Leatha is by appointment only. In order to best serve my clients I schedule no more than five clients per day. This allows ample time before and after the massage for a relaxed and stress free experience. Due to high demand for my services there is often a waiting list of clients hoping to get an appointment for a variety of conditions including pain and high stress. If you are unable to attend your appointment, I may be able to accommodate another client needing treatment. Please provide a 24 hour notice if you are unable to attend your scheduled massage therapy appointment. Failed appointments or those cancelled within 24 hours of your appointment will be charged a $25 cancellation fee. Emergencies or weather cancellations will not be charged the cancellation fee. I look forward to working with you.
Client Initials: _____

Consent to treat:
I understand that massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch. The general benefits of massage, possible massage contraindications, and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatments or medications, and that is it recommended that I concurrently work with my primary care giver for any condition I may have. I am aware that the massage therapist does not diagnosis illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical, psychological, and medical conditions, and medication and will keep the massage therapist updated on any changes.

Client signature: _____ Date: _____