A to Zen
Massage • Yoga • Wellness

Client Information Form

All information is confidential. It will not be shared with or sold to any other companies or parties.

Name _____ Birthday _____
Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email Address_____@_____
Please indicate the best way to reach you about your appointments _____
Would you like to receive texts or emails for appointment reminders/confirmations?_____
Would you like to receive text messages about specials or open appointment times?_____
If yes to either above, who is your mobile provider?_____
Who should we contact in case of emergency? _____ Phone_____
How did you hear about us? (Or who should we thank for referring you?) _____

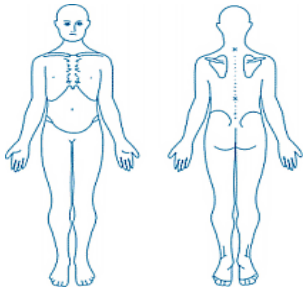
Massage Treatment Intake

Have you had a professional massage before? _____ If so, when was your last session?_____
What is your occupation? _____
Circle the primary purpose of today's visit? pain relief relaxation pampering other _____
Have you ever been hospitalized? _____ For what/when?_____

Please list any significant injuries and when they occurred. _____
_____
Please list any current medications. _____
Please circle any symptoms/conditions that are current or have been present in the last six months:
Allergies Phlebitis Pregnancy Chest pain Headaches Dizziness Anxiety Fatigue
Sinusitis Head cold Bronchitis Eye strain Breathlessness Varicose Veins
Abdominal pain Urinary/Menstrual Problems Digestion Problems Other _____

Please circle any conditions that are present now or have occurred in the last five years:
Thyroid problems Kidney disease Emphysema Diabetes HIV/AIDS Polio Hernia
Scoliosis Ulcers Cancer High/Low Blood Pressure Hepatitis Weight Problems
Hypoglycemia Degenerative Disc Disease Heart Disease Asthma Other _____

Please mark any areas of pain or tension below:



Do you wish to receive massage on the gluteal/hip area? (Circle one) YES NO
Do you wish to receive massage on the abdominal area? (Circle one) YES NO

I understand that massage therapy is not a substitute for medical care and will seek care from a licensed medical provider when needed. I will also keep my massage therapist informed of any new conditions, injuries or illnesses that occur. By signing this form, I am giving my informed consent to receive massage therapy, hot/cold therapy and the various stretching techniques used by my massage therapist. Further, I agree to abide by the 24 hour cancellation policy for my appointments and agree to pay for any missed appointments or late cancellations.

Client Signature _____ Date _____

Office Use Only: TY _____ MBO_____ RC _____