CLINIC RECORD

*Date*_____

*Name*_____*Address*_____

*Phone(__)*_____*Date of Birth*_____*#Children*____*Occupation*_____

*Pregnant*___*Weight*___*Height*___*Smoke*___*Glasses/ Contacts*___*Medications*_____

*Referred by*_____*Reason for Massage, Personal growth*_____

*Stress*___*Injury / Pain*_____*Other*_____

*Exercise choice and frequency*_____

*Physical discomfort / Recent injury*_____

*Location(s) and Description*_____

Is there specific movement or activity associated with the condition ? _____

_____

*Date of onset*_____*Is there a physician treating you now or recently ?* ___

*If yes, for what condition ?*_____

If you currently have, or within the last year had, any of the following, indicate and give details below or on the back of this page :

Y__N__DIVERTICULITIS	*Y__N__SKIN CONDITION*	*Y__N__CANCER*
Y__N__VARICOSE VEINS	*Y__N__HERPES*	*Y__N__HEART PROBLEMS*
Y__N__PHLEBITIS	*Y__N__AIDS / ARC / HIV+*	*Y__N__HIGH BLOOD PRES.*
Y__N__FRACTURES	*Y__N__PREGNANCY*	*Y__N__HEMATOMAS*
Y__N__INSOMNIA	*Y__N__WHIPLASH*	*Y__N__ARTHRITIS*
Y__N__HEADACHES	*Y__N__CONSTIPATION*	*Y__N__ANY CONTAGIOUS DISEASE*
*Y__N__OTHER*_____		

I understand that the services offered are not a substitute for medical care and that any information provided by the therapist is for educational use and is not diagnostically prescriptive in nature. I agree to actively participate, as much as possible, in my own healing.

_____

Client's Signature