Client Information

Tina L Manning, LMT 231-392-9381 tmanningcmt@gmail.com

Client Name: _____ Date: _____

Address: _____

Home Phone: _____ Cellular: _____ text

Date of Birth: _____ Gender: Male Female

Occupation: _____ Height: _____ Weight: _____

Emergency Contact: _____ Phone: _____

Email: _____ Referred by: _____

Have you received massage therapy before? By _____ When _____

The primary reason for this appointment is (circle all that apply):

Pain Relief Sports Injury Muscle Spasm Arthritis Medical Condition Bone Fracture

Auto Accident Joint Injury Pulled Muscle Nerve Damage Range of Motion Stress/Tension

Describe these problems and when they began _____

_____

Have you received medical care for these problems? Yes No When? _____

(circle all that apply) D.O. M.D. Surgeon Chiropractor Nurse Phys. Therapy

Do you currently have a cold, flu, virus, infection or other contagious condition? No Yes

Do you have any allergies? No Yes _____

What is your current level of pain: low 1 2 3 4 5 6 7 8 9 high

Do you wear (circle): Dentures Contacts Hearing Aids Hairpiece Prosthetics

General Health (circle one): Poor Fair Good Excellent

Blood Pressure: Low Normal High

Heart Attack: Yes No When _____

Stroke/TIA Yes No When _____

Pacemaker/Defibrulator: Yes No When _____

Diabetes Yes No When _____

Cancer Yes No When _____

Congestive Heart Failure Yes No When _____

Broken bones or surgeries? Yes No When _____

If so, explain _____

Are you currently receiving medical care for any other issue: Yes No

If so, explain _____

Please list the types of medications you are currently taking: _____

_____

What are your goals and expections for receiving massage therapy? _____

_____