Flow Wellness Massage Therapy

Client History Form

Name: _____
Date: _____ Age: _____
Phone: _____ Emergency #: _____
Address: _____
Email: _____
(Do you wish to be added to our mailing list? Please circle: Yes / No)

Occupation: _____
Recreational Activities/Hobbies: _____

Have you ever had a massage before? Yes / No (circle)

Reason for treatment: _____
Areas you would like to address: _____

General Health Condition: _____
Have you had any operations, illnesses, accidents and/or any muscle/bone/joint injuries? Y / N (circle)
If YES, explain:
_____
_____

Are you presently taking any prescribed medication(s)? Y / N (circle)
Taken any medication within the past hour? Y / N (circle)

General Information: Please check/circle all that apply.

Hand dominance? Right / Left (circle)
Energy Levels: Poor_____ Fair _____ Good _____ Excellent _____
Nutritional Habits: Poor_____ Fair _____ Good _____ Excellent _____
Daily Water Intake: Yes / No Glasses per day: _____
Sleep Patterns: _____
Stress level: Normal _____ High _____ Low _____
Do you smoke? Yes / No
Do you have a wellness/self-care program? _____

Anything else you wish to share that would help you in this healing process?

I, _____,
do hereby grant RMT Erin O'Neil (Flow Wellness Studio), permission to provide Massage Therapy to me, as discussed on this day, (DD/MM/YYYY) ____/____/_____.

I understand that I am financially responsible to Erin O'Neil for the cost of this treatment.

I also agree that the information discussed with the therapist Erin O'Neil, as well as written on this form, is true to the best of my knowledge.

Client Signature: _____ Date: _____

All patient information is confidential and will not be released without signed consent by the patient.