

Anita Crew's Massage Therapy
541-659-4864
CONFIDENTIAL CLIENT INFORMATION FORM

Name: _____ Date of Birth: _____

Address: _____

Phone Number(s): (h) _____ (w) _____ (c) _____

E-mail: _____ How did you hear about us? _____

Occupation: _____ Exercise / Activities _____

MEDICAL BACKGROUND

Do you have any of the following? (Please circle all that apply)

Blood Clots	Joint Replacement	Neck/Back/Spine Problem	Difficulty Breathing
Pregnancy	TMJ Syndrome	Asthma	Surgeries
Cancer	Skin Disorders	Osteoporosis	Headaches
Heart Conditions	Varicose Veins	Seizures	Infections
High Blood Pressure	Fibromyalgia	Bursitis	Diabetes
Stroke	Arthritis	Circulatory Condition	Injuries
Disk problems	Cold/Flu Symptoms	Ulcers	

Comments: _____

Please list any past accidents and surgeries: _____

Please list any medications that you are taking: _____

MESSAGE BACKGROUND

Have you ever received professional massage? _____

Are you allergic/sensitive to any oils or creams? _____ If yes, what type: _____

Reason for Visit (circle all that apply): Relaxation Pain Relief Relaxation+Pain Relief

List specific areas of the body for Pain Relief work _____

Depth of pressure preferred (circle): Light Medium Heavy

Please list any areas of the body that you would prefer not be worked on: _____

I understand that therapeutic massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. Because therapeutic massage/bodywork should not be performed under certain circumstances, I affirm that I have stated all medical conditions of which I am aware and will inform my practitioner of any changes in my medical status.

Signature: _____

Date: _____