THAI•THERAPY•STUDIO
New Client Information

Form 1-A
Rev 8-11

Name: ______________________ Date: __________
Address: ______________________
Home Phone: __________ Cell: __________ Work: __________
Email address: ______________________ Marital Status: __________
Birthdate: __________ Age: ______ Height: ______ Weight: ______
Occupation/Employer: ______________________
Emergency Contact: ______________________ Phone: __________
How did you hear about Carrie? ______________________
May we contact your physician? ______ Name & Phone: ______________________

PLEASE COMPLETE WITH AS MUCH DETAIL AS POSSIBLE

Reason for appointment: ______________________
Have you ever had a professional massage? Y N
Are you currently under the care of a physician, chiropractor, or other therapist? Y N
If yes, what are you being treated for? ______________________

Have you ever had surgery? Y N
If yes, please describe: ______________________
Do you have *current* medical issues and treatments? Y N
Please describe: ______________________

Do you have *past* medical issues and treatments? Y N
Please describe: ______________________

Do you take any medications, vitamins and/or supplements? Y N
Please describe: ______________________

Do you have any skin conditions or allergies? Y N
Please describe: ______________________
Have you suffered an acute injury or accident? Y N
Please describe: ______________________

Have you suffered a major illness or disease? Y N
Please describe: ______________________
Any recent breaks or sprains? Y N
Please describe: ______________________
Do you have any joint problems? Y N
Please describe: ______________________
Do you have headaches and/or migraines? Y N
Please describe: ______________________
Do you exercise regularly or participate in any sports? Y N
Please describe: ______________________
Do you have any other medical conditions or concerns? Y N
Please describe: ______________________

PLEASE CHECK ALL THAT APPLY TO YOU (PRESENT OR PAST)

________	Heart Problems	________	Arthritis	________	Sleep Difficulty
________	High Blood Pressure	________	Osteoarthritis	________	Dizziness
________	Blood Clots	________	Wear Contacts	________	Stress
________	Pacemaker	________	Wear Dentures	________	Menstrual Issues
________	Varicose Veins	________	Pregnant	________	Diabetes
________	Cancer	________	Spinal Problems	________	Back problems
________	Neurological Problems	________	Disk Problems	________	Headaches

Comments on the above: ____

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Additional Notes: ____

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CONSENT FOR MASSAGE AND OTHER THERAPY SERVICES:

I understand that the services given here are for the purpose of relaxation and or pain reduction, relief from muscular tension or spasm, or for increasing circulation, and energy flow. It is my choice to receive services as a form of treatment.

I undersand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that services received are not a substitute for any physical ailment that I might have, or a substitution for medical examination and/or medical diagnoses.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions. I take it upon myself to keep the massage therapist updated on on any changes to my health, and any recommendations and/or restruction on the part of my medical doctor or therapist.

I understand that if I cancel a session less than 24 hours in advance I may be billed for the full session amount.

Signature: ______________________________ **Date:** ______________

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