cortiva institute
Chicago School of Massage Therapy

Client Information Form - Professional Clinic

Name _____ Date _____

Address _____ City/State/Zip _____

Telephone (home) _____ (work) _____

Occupation _____ Email _____

Date of birth _____ How did you hear about us? _____

Primary reason for appointment _____

Areas of complaint, pain or tension _____

When did you first notice complaint? _____

Is this condition getting progressively ☐ worse ☐ better ☐ or comes and goes?

Is this condition interfering with your ☐ work ☐ sleep ☐ daily routine?

What have you done to obtain relief? _____

Has there been a medical diagnosis? ☐ yes ☐ no What is it? _____

Were you hospitalized with this condition? _____

Are you currently under the care of a physician? ☐ yes ☐ no

Physician's name _____ Telephone _____

Are you taking any medications? ☐ yes ☐ no Please list them _____

Have you had any surgeries? ☐ yes ☐ no Description/Date _____

Have you had any broken bones? ☐ yes ☐ no Description/Date _____

Have you had any vehicle or other traumatic accidents? ☐ yes ☐ no If yes, please describe direction and type of impact and date.

_____

Do you have a medical condition that requires a modification in massage technique? ☐ yes ☐ no

If yes, please describe. _____

Please list any of the following that apply to you:

☐ Allergies ☐ Arthritis ☐ Blood clots ☐ Diabetes ☐ Dizziness
☐ Headaches ☐ Heart Problems ☐ High Blood Pressure ☐ Joint Disease ☐ Low Blood Pressure
☐ Open lesions or cuts ☐ Pregnancy ☐ Spinal Problems ☐ Skin Problems (specify) _____
☐ Varicose veins ☐ Other (specify) _____

Have you had a massage at the school clinic before? ☐ yes ☐ no

Do you exercise or participate in sports regularly? ☐ yes ☐ no

If yes, which sport(s) and/or how often do you exercise? _____

Do you feel you eat a balanced diet? ☐ yes ☐ no

Please describe your general consumption of the following:

	High	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

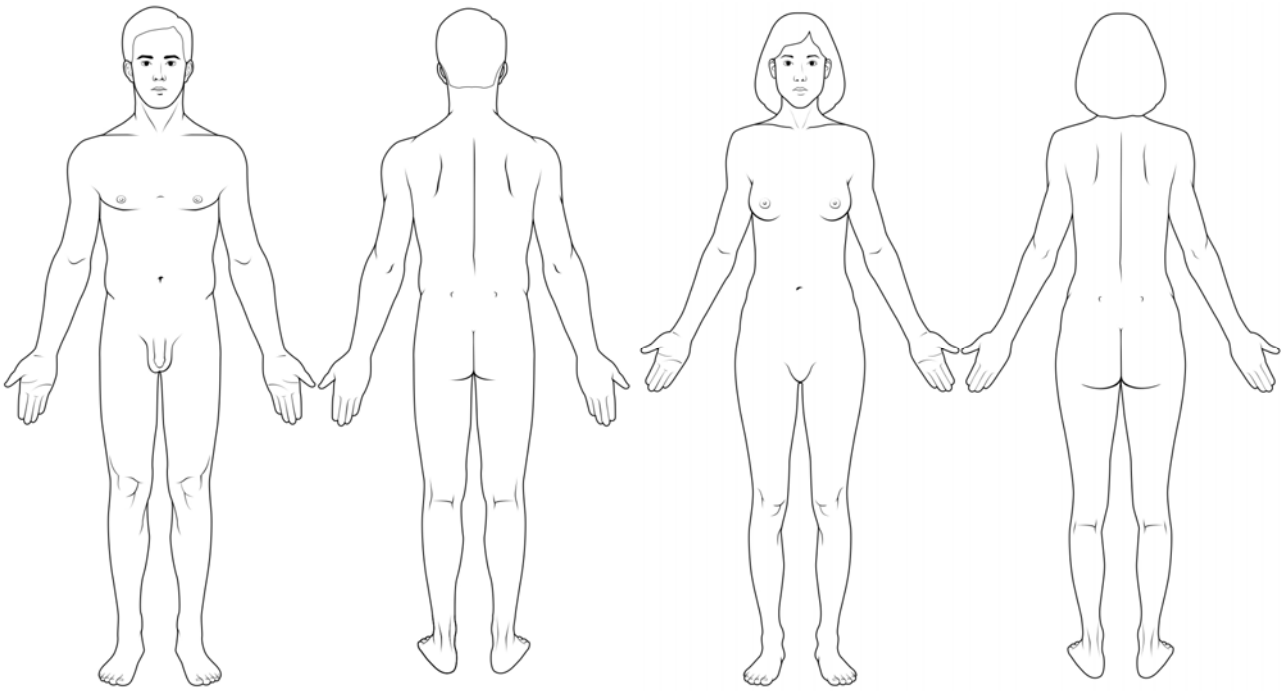
Describe your stress level: ☐ ☐ ☐ ☐

Do you sleep on your ☐ side ☐ back ☐ stomach? (check all that apply)

Do you wear contact lenses? ☐ yes ☐ no Dentures of other dental appliances? ☐ yes ☐ no

Are you wearing orthotic inserts? ☐ yes ☐ no For how long? _____

Please indicate any areas of complaint by marking them on the figures below.



If you have pain, please circle your level of pain: (little pain) (very painful)

1 2 3 4 5 6 7 8 9 10

Name any area(s) that you do not want addressed during the session: _____

I, the undersigned, understand that massage therapy is for the purpose of stress reduction, relief from muscular tension, general relaxation and improvement of circulation. I also understand that the massage therapist does not diagnose illness, disease, or physical or mental disorders; does not prescribe medical treatments or pharmaceuticals; nor do they perform any spinal manipulations. It has been made clear to me that professional massage therapy is not a substitute for medical treatment and that it is recommended that I see a physician for any physical ailment that I might have. I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on changes in my physical health. With this in mind, I agree that the massage therapist cannot be held liable for any problems that might arise as a result of my massage sessions.

Signature _____

Client Session Record

Client Name: _____

Date	Therapist or Student & Class	

Client Session Record

Client Name: _____

Date	Therapist or Student & Class	