Touch for the Wise

Client Evaluation Form

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____

Referring Physician & Phone: _____

Relative & Phone: _____

Prescriptions, and what time of day do you take them?

_____

_____

Known side effects from prescriptions:

_____

Primary Complaint or areas of Tension:

Client Evaluation Form

Do you have?: (Check all that apply)

	High Blood Pressure		Thrombosis
	Poor Blood Circulation		Surgery, when?
	Arteriosclerosis		Mastectomy, when?
	Fainting		Edema
	Diabetes Mellitus		Allergies
	Osteoporosis		Asthma
	Osteoarthritis		Chronic Bronchitis
	Rheumatoid Arthritis		Emphysema
	Aneurysm		Multiple Sclerosis
	Skin Rash, where?		Parkinson's
	Limited Range of Motion, where?		Hernia, where?
	Joint Replacement, where?		Scoliosis
	Stroke,when?		Kyphosis
	Paralysis		Lordosis
	Hearing aids or other implants?		

Anything else I should be aware of?

Touch for the Wise

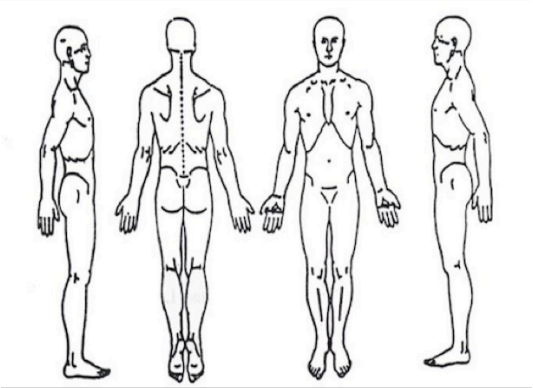
Client Evaluation Form

Have you had a professional massage before? _____

When: _____

Please indicate areas, on the diagram that you would like more focused attention with an **O**.

Also, areas that you do not want massaged with a **X**.



I understand that the therapies given here are for the purpose of stress reduction, relief from muscular tension or spasm, and for increasing circulation and energy flow. I understand that the therapist does not diagnose, treat, or prescribe for any illness, disease or any other physical or mental disorder. It has been made clear to me that these therapies are not a substitute for medical examinations and/or diagnosis and that it is recommended I see a physician for any ailment I might have. With this in mind, I agree to have this massage.

Signature: _____ Date: _____

Client Name: _____