CONFIDENTIAL

Massage Client Information Form

BodyWorkJUNKI massage & wellness

Patient Details

Surname: ..... Given Names: .....

Address: .....

Home Phone: ..... Mobile: ..... Date of birth: ..... /..... /.....

Email: .....

Emergency Contact Person: ..... Phone: .....

Health Fund

Health Fund? Yes/No Name of health fund: .....

Your Health Details

Occupation: ..... Physical Related Job Duties: .....

Please indicate if you have had or presently have problems in any of the following areas:

Chronic Pain	Herpes	Blood Clots	Headaches
Dizziness	Shingles	Osteoporosis	Allergies
Cold/Fever	Eczema	TMJ Syndrome	Arthritis
Diabetes	Psoriasis	Neck/Spinal Injury	Epilepsy
High Blood Pressure	Skin Disorders	Loss of balance	Insomnia
Health Ailments	A.I.D.S	Numbness	Pregnancy
Kidney Ailments	Phlebitis	Fatigue	P.M.S Syndrome
Cancer	Varicose Veins	Depression	Sleep Disorders
Infectious Conditions	Joint Replacement	Nervousness	Surgery

Other Medical Conditions not listed:

.....

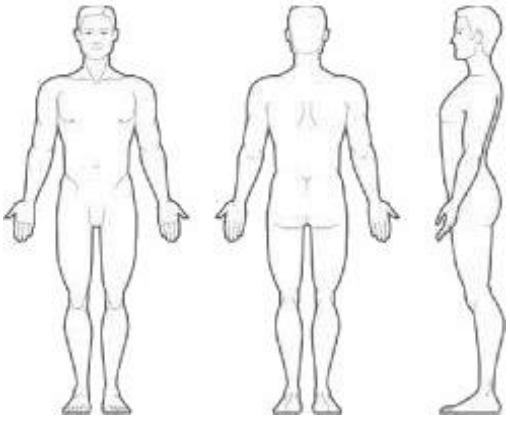
Are you on any Medications (list):

.....

Have you had any prior treatment for you presenting complaint (list)? Yes/No .....

.....

Circle areas of Soreness:



Please sign and date the following statement: I confirm that all information provided here is true and that I have not omitted any information concerning my health. I accept full responsibility for advising the therapist of any changes to my medical circumstance when I visit in the future.

Signature: ..... Date: .....

How did you hear about our Services? .....

Would you like to be added to our newsletter database? YES/NO