

# Client Information Form

Cortney Phillips RMT

(214) 783-4275

## Contact Information

Name & Birthday \_\_\_\_\_

Address: \_\_\_\_\_

Street

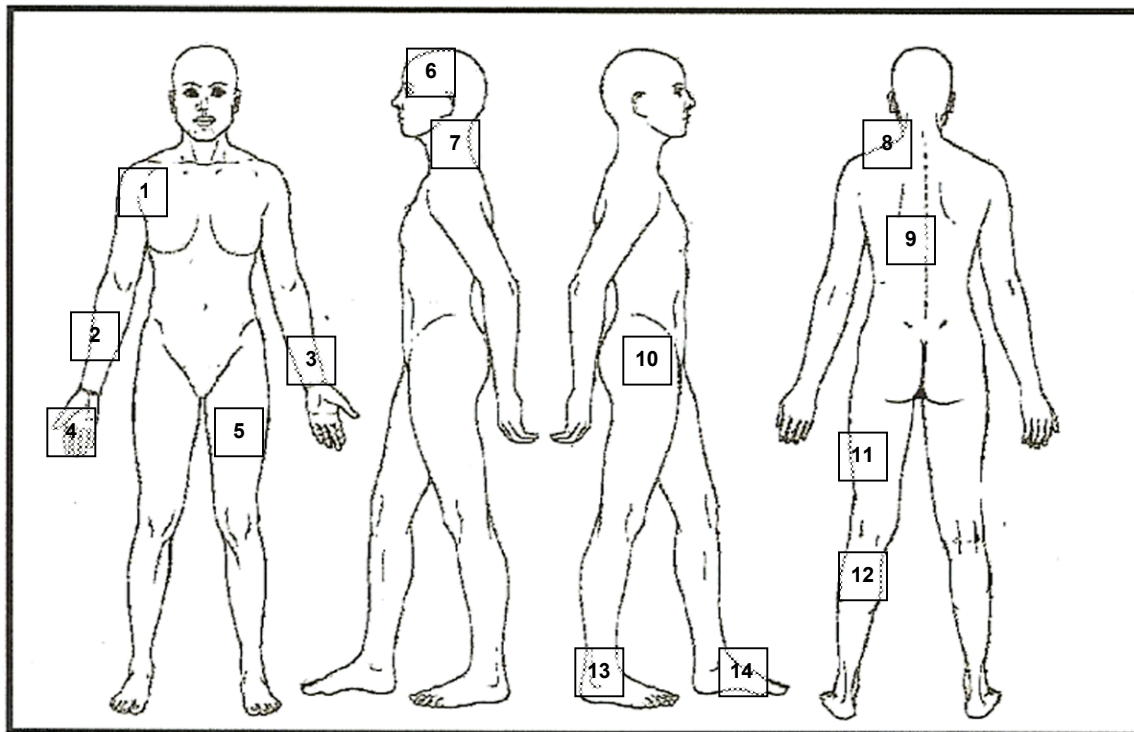
City

Zip

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Specific Concerns: \_\_\_\_\_

Please indicate specific areas you would like the massage therapist to concentrate on during the session:



1. Upper arms/chest
2. Forearms
3. Wrist
4. Hands
5. Thigh/quadriceps
6. Scalp
7. Neck
8. Shoulder

9. Back
10. Hips
11. Hamstrings
12. Calves
13. Ankles
14. Feet
15. Other: \_\_\_\_\_

## Please Check:

### Have you had or do you have?

1. Allergies to lotion
2. Allergies to oil
3. Allergies to fragrance
4. Arthritis
5. Asthma
6. Blood clots
7. Bursitis
8. Epilepsy
9. Heart Trouble
10. High blood pressure
11. Infectious disease
12. Low blood pressure
13. Migraine headaches
14. Recent injury
15. Recent surgery
16. Skin problems
17. Spider veins
18. Varicose veins
19. Spinal injury

### Are you currently?

20. Taking medication
21. Pregnant  
(If yes, please fill out "Prenatal Release Form")
22. Other:

*PLEASE READ THE FOLLOWING STATEMENTS & SIGN AT THE BOTTOM*

I understand I will be participating in massage therapy as a form of adjunct health care. I understand that this massage is not to be used in place of medical treatment. I am aware that draping will be used during the massage session. I understand that my feedback is an essential element in my treatment, therefore if at any time I should become uncomfortable during the massage, I may bring it to my therapist's attention and request the session end. I understand that professional standards will be held at all times. I have submitted correct information regarding my state of health, medical history, injuries, and/or surgeries and will advise the therapist of any changes that occur in that information.

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Client Signature

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