

SUSAN GRAY WELLNESS

Susan L. Gray, RCST, LMT, CLA

Registered Craniosacral Therapist - Therapeutic Massage for Adults, Teens and Children

Specializing in Pregnancy and Labor Support Education

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CLIENT INFORMATION FORM

Date: _____ Name _____ Address _____

City/State _____ Zip _____ Age: _____ Date of birth: _____

e-mail: _____ Tel:(hm): _____ (cell): _____

Occupation: _____

Referral Source: _____ Have you ever had a massage before? Y/N

Primary reason for appointment?

List areas of complaint, pain or tension:

Are you now under medical/therapeutic treatment? Yes No

If so, for what condition?

Physician or Practitioners name _____ Tel# _____

Please list any medication you are taking (including aspirin): _____

Please (date/describe) any accidents or operations:

Please circle any of the symptoms or physical problems listed below that you are currently experiencing or have experienced:

Allergies

Arthritis

Asthma

Heart Condition

Cancer

Anxiety

Depression

Sinusitis

Blood Clot

Varicose veins

Diabetes

Hip Replacement

Joint disease

Spinal Problems

Insomnia

High/Low blood pressure

Respiratory/lung

Numbness

Scoliosis

Fatigue

Headaches

Sciatica

Fractures

Broken ribs

Fibromyalgia

Fibrotic Cysts

Pregnancy

Poor Circulation

Skin problems/warts/rashes, please specify _____

CLIENT IN-TAKE FORM (CONTINUED)

Do you practice any type of relaxation? If so, what kind _____

Do you exercise regularly? Y/N If yes, what type of exercise are you participating in?

Describe your diet? _____

How many glasses of water do you drink per day?

How many hours of sleep do you average at night?

Please list any hereditary disorders or diseases of immediate family member:
(such as heart disease, scoliosis, multiple sclerosis, etc.)

Mother _____

Father _____

Siblings _____

Is there any other medical information that I should know before proceeding with
massage? _____

Thank you for your professional consideration, courtesy, and promptness.

CONSENT for CARE

I _____, understand the massage therapy is for the purpose of stress reduction,
relief from muscular tension, general relaxation and improvement of circulation.

I understand 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 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 my known medical conditions and take it upon myself to keep the massage therapist
updated on my physical health.

A \$50 cancellation fee will be charged to client without 24 hour notice.

Signature _____ Date _____