



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:

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Open lesions or cuts | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Spinal Problems | <input type="checkbox"/> Skin Problems (specify) _____ | |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

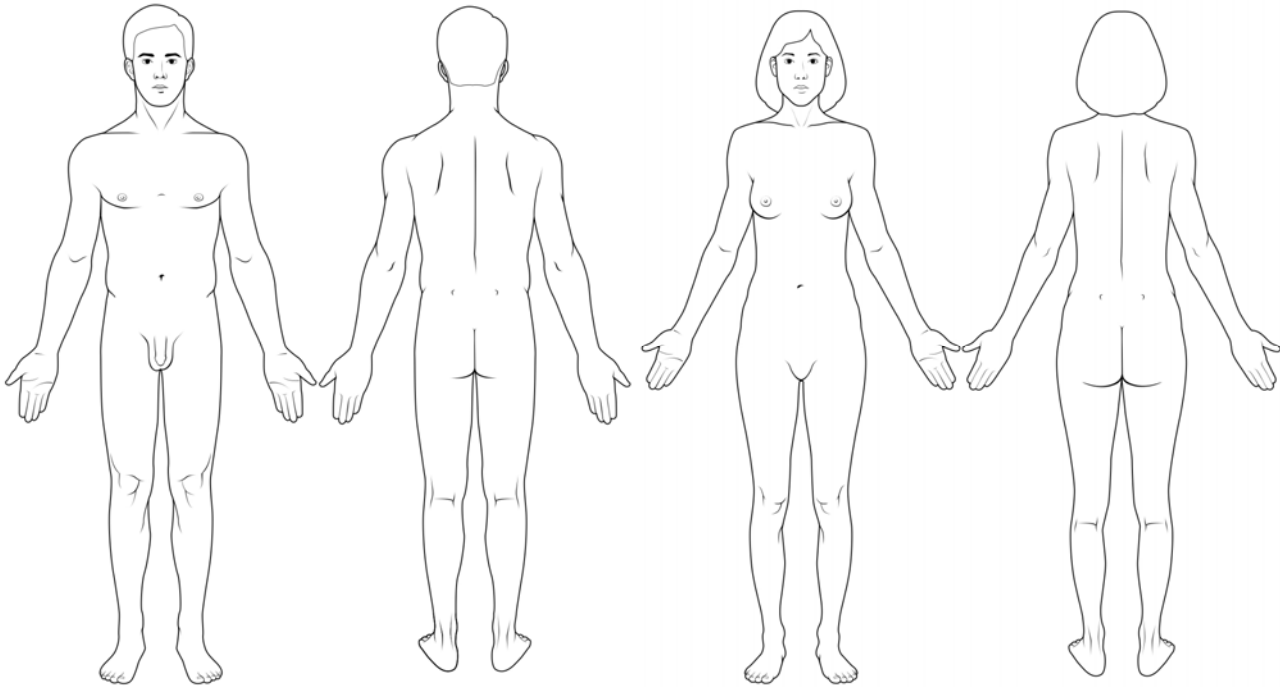
Describe your stress level:

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

Do you wear contact lenses? yes no Dentures or 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 _____

