CONFIDENTIAL CLIENT INFORMATION

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Salem, OR 97301

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone _____ Were you referred? Y ☐ N ☐ By Whom? _____

Email _____ Occupation _____

Would you like to receive occasional newsletters from 8 Hands Healing? Y ☐ N ☐

Do you see a chiropractor? Y ☐ N ☐ Name_____ Treatment is for _____

Personal Physician _____ Phone _____

Health History - If you check any of the following, please describe more fully the circumstances

Please check if applicable
- ☐ Prescription medication
- ☐ Circulatory problems
- ☐ Contact Lenses
- ☐ Pregnant
- ☐ Ruptured or herniated disc
- ☐ Skin irritations
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Smoke
- ☐ Varicose veins

Please describe
Communicable diseases _____
Car accidents _____
Current illness _____

Broken bones _____
Surgeries _____
Current injury _____
Cancer _____
Allergies _____
Under Doctors care _____
Stress_____
_____

List all current medications, symptoms, and diagnosed conditions *(Use back of paper if more room is needed)*

_____

_____

How much **water** *(other liquids not included)* do you drink per day? **1 glass = 8 oz.**

☐ 1- 2 glasses ☐ 3-5 glasses ☐ 6-10 glasses ☐ 11 or more

Other liquids: Cups of: coffee _____ juice _____ soda _____ tea _____ other _____

Are you currently off certain foods? Please list _____
What results are you looking for **today?** ☐ Relaxation ☐ Injury/Recovery Specific area of Concern_____
What are your long term health goals?

_____

_____

I acknowledge that massage is not a substitute for a medical examination or treatment, and that it is recommended that I see a physician for those services. I understand that massage should not be performed under certain medical conditions, and I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my health and will not hold the therapist liable for any information I've forgotten or left out. I understand that I am responsible to pay for any appointment not canceled at least 24 hours in advance. **I understand that soreness in the muscles after a massage or bodywork can occur due to an insufficient intake of water to flush toxins through my system.** I, the undersigned, state the above information is true and complete to the best of my knowledge. When form is filled out, click SUBMIT on top of page to send. Thank you!

Signature _____ Date _____