Client History Form

All information provided is completely confidential

Name: _____ **Date of Birth:** _____

Occupation:_____ **Where do you work?** _____

Mob: _____ **Email:** _____

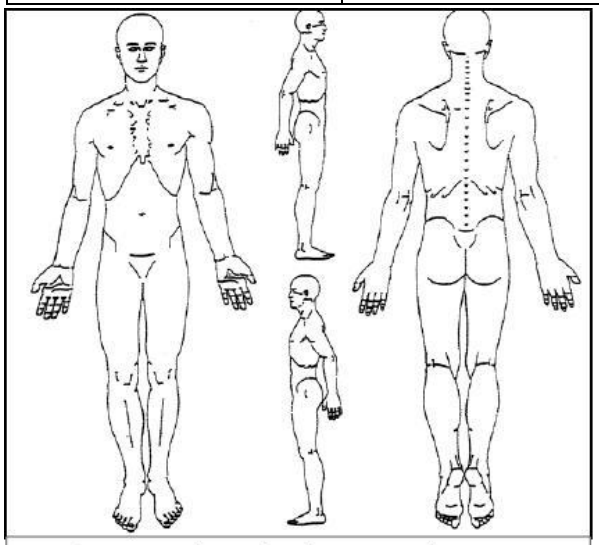
How did you find out about Maintain? Advertising/ Signage/ Friend/ Work/ Event/ Search Engine/ (circle)

Referral (Who?): _____

Do you have any of the following conditions? (circle and specify if any apply)

Allergies	Operations	Asthma / Breathing Problems
Arthritis/Gout	Skin Conditions	High / Low Blood Pressure
Blood Clots	Easy Bruising	Numbness/Tingling
Cancer	Cold/Flu	Viral Conditions
Heart Problems	Diabetes Type 1 / 2	Vision Problems / Dizziness
Stress / Fatigue	Bone Fractures	Fluid Retention general or advanced
Accidents / Whiplash	Headaches	Pregnancy (wks___)
Sleep Disturbance	Migraines	Other:

Medication? Specify:



Please mark in the diagram above any areas where you have pain or discomfort.

Sudden event or injury causing issue? (specify)

Sport / Hobbies related to issue? (specify)

Water intake per day
Coffee/Tea
Do you smoke?

Type of Pain?
Does movement help?
Has anyone given you a diagnosis?

Have you had a massage before?	
Sensitive to pressure?	Pressure preference?
What are your goals from massage treatment?	

This massage should feel comfortable. If at any time you experience pain or discomfort, please let your practitioner know.

I understand that massage therapy is designed to be a health aid and does not take the place of a doctors or physiotherapists care and I am aware of our cancellation policy

Signed: **Date:**