(CWCM Confidential Client Information)

PERSONAL INFORMATION

Name _____ Birthdate _____

Address_____ City/State _____ Zip _____

Occupation _____ Daytime Phone _____ Evening Phone _____

E-Mail _____ Referred by _____

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Major Complaints/Symptoms	Onset Date			
1. _____	_____	Is this related to a recent accident?	Y	N
2. _____	_____	Motor Vehicle Accident?	Y	N
3. _____	_____	Work related accident?	Y	N
4. _____	_____	Other Type of accident?	Y	N

Please list all physicians (MD's or DC's) who are treating you at this time and for what you are being treated.

_____

_____

_____

_____

_____

Please list all falls, accidents, injuries, or illnesses which required medical attention in the past and may be affecting you today.

_____

_____

_____

_____

_____

Please list all surgeries _____

_____

_____

Please list all medical conditions affecting you at this time _____

_____

Please list all medications you are taking and what they are used for _____

_____

_____

_____

Certain medical conditions may contraindicate massage therapy as a form of treatment. A referral from your primary care provider may be required in such a case. Also understand that massage therapists are not permitted to diagnose any physical or mental illness, and that nothing said in the course of any session should be misconstrued as such. I affirm that I have answered all questions honestly and accurately and that I have stated all my known medical conditions.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Cancellation of an appointment without providing 24 hours advanced notice may result in you being billed for 50% of the scheduled appointment. All "no shows" will be billed for 100% of the scheduled appointment.