

Confidential Client Information Form

Ramon Bacauí Hair and MedSpa

Name _____ Age _____ Birthday _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Phone(H) _____ (C) _____

Referred by _____ Allergies to oils or fragrance _____

Any Injuries or accidents _____ Describe _____

Pins or Wires in your body _____ Taking any medications and/or herbs? Y/N

Please list _____

Areas of complain or tension _____

Primary goal or reasons for appointment _____ Contact Lenses Y/N

Please check all conditions listed below which you have experienced. Write a P for past conditions and C to indicate current conditions.

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stress/Fatigue | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Spinal Problems/Backaches | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Recent Surgery | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood Clots/Phlebitis | <input type="checkbox"/> Asthma/sinuses | <input type="checkbox"/> Neck/Spine Injury |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Headaches/Migraine | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High/Low blood Pressure | <input type="checkbox"/> Thrombosis | <input type="checkbox"/> Now Pregnant |
| <input type="checkbox"/> High/Low blood Sugar | <input type="checkbox"/> Stroke | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Edema (water retention) | <input type="checkbox"/> Depression |

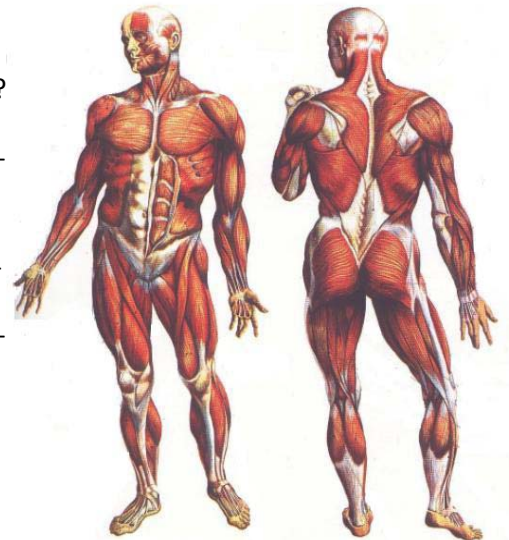
Do you have any other medical conditions that I should be made aware of?

Stress Level (1=very low ---- 5= very high)

1 2 3 4 5 Explain _____

Depth of pressure desired: Light Medium Deep

On the figure on the right, please circle any areas where you are feeling tightness, tension, or pain.



I _____ have read the above information and have stated all my known medical conditions. I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, for increasing circulation and energy flow, and relief from stiff joints. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. I take it upon myself to update my massage therapist regarding any changes in my condition.

Signature _____ Email: _____ Date _____

Therapist's Signature _____ Date _____

Subjective***O**bjective***A**ssessment***P**lan NOTES. Date: _____ LMT's Name _____

S: _____

O: _____

A: _____

P: _____

SOAP NOTES Date: _____ LMT's Name _____

S: _____

O: _____

A: _____

P: _____

SOAP NOTES Date: _____ LMT's Name _____

S: _____

O: _____

A: _____

P: _____

