Client Information Sheet

(To be completed by client before or at time of service)

CLIENT INFORMATION Date: _____

Name: _____

Address: _____

City_____ State: _____ Zip: _____

Date of Birth: _____ SSN (optional):_____

Daytime phone: _____ Cell phone: _____

Email: _____

Occupation_____

PRIMARY CARE PHYSICIAN (PCP)

PCP Name: _____

Location/Hospital: _____

Phone Number: _____

EMERGENCY CONTACT

Name: _____

Relationship to Patient: _____

Phone Number: _____

AKNOWLEGMENT

The client understands that a massage therapist is not qualified to diagnose medical conditions, or make medical recommendations. The client is responsible for payment at time of service.

Client Signature: _____ Date: _____

Add your practice/clinic name here