www.ibodycare.com
608 S. Washington Street, Naperville, IL 60540

Chair Massage Client Information Form

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone (_____) _____
Work Phone (_____) _____
Home email _____
Work email _____
Site of Chair Massage _____
Medication (s) _____
_____
_____
Medical concern (Please explain)
1. **Back** - **Neck** Now/Prior _____
2. **Cancer** Now/Prior _____
3. **Heart** Now/Prior _____
4. **Broken bones or fractures** Now/Prior _____
5. **Tension, stress, anxiety, depression** Now/Prior _____
_____
6. **Overweight** Now/Prior **Underweight** Now/Prior _____
7. **Skin problems** Now/Prior_____
8. **Other** Now/Prior _____
_____

Are you under the care of a physician? Yes/No
(contacted only by permission)
Physician Name _____
Address _____
Phone _____

I understand that _____ does NOT diagnose or treat illnesses or injuries. I am solely responsible for my physical condition and for seeking medical treatment when I feel it is necessary for my well-being.

Please sign _____

Date _____

Therapist's Signature _____ 10/29/98