



# Institute Of Russian Healing Arts

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## Client File Form

In order to maximize the effectiveness and safety of the sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Please, use the back side of this page if extra space is needed. Your feedback is appreciated during and at the end of a session, so we may serve you in the best possible way.

Date of initial visit \_\_\_\_\_ Full Name \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_

State and Zip code \_\_\_\_\_ Referred by \_\_\_\_\_

Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_ Date of birth \_\_\_\_\_

Your e-mail address \_\_\_\_\_ Would you like to join our mailing list? \_\_\_\_\_

Occupation(s) and Interests \_\_\_\_\_

What is your goal/concern for today's session?

What is your previous experience with professional massage?

Do you experience any difficulty lying either on your front or your back?

Is there any area where you would like extra time spent, any area where you seem to hold a lot of tension?

Habits: Exercise \_\_\_\_\_

Tobacco \_\_\_\_\_ Alcohol \_\_\_\_\_ Caffeine \_\_\_\_\_

Posture assumed most of the day \_\_\_\_\_ Sleep \_\_\_\_\_

### Medical History:

Yes  No  Hypertension

Yes  No  Heart disease

Yes  No  Arteriosclerosis

*Next page, please*

Yes  No  Skin sensitivity

Yes  No  Allergies

Yes  No  Herpes I or II

Yes  No  Varicose Veins  
Yes  No  Phlebitis  
Yes  No  Epilepsy  
Yes  No  Headaches  
Yes  No  Cancer/malignancy  
Yes  No  Diabetes  
Yes  No  PMS/Painful menstruation  
Yes  No  Easy bruising  
Yes  No  Skin rash  
Yes  No  Abscess or open sore

Yes  No  Mental illness  
Yes  No  Osteoporosis  
Yes  No  Osteoarthritis  
Yes  No  Rheumatoid arthritis  
Yes  No  Fibrositis  
Yes  No  Herniated Disc  
Yes  No  Inner ear problem  
Yes  No  Pregnancy  
Yes  No  HIV+/AIDS  
Yes  No  Dizzy spells

Yes  No  Surgery/fractures. If yes, please explain:

Yes  No  Musculoskeletal pain/stiffness. If yes, please explain:

Yes  No  Any other physical or emotional difficulties. If yes, please explain:

Do you wear contacts ( ), dentures ( ), or hearing aid ( )?

Yes  No  Are you under medical care or supervision now? For what condition?

Yes  No  Are you currently taking any medication? If so, what?

Do we have permission to contact your doctor should the need arise?

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

*To the best of my knowledge, I have disclosed all information about my condition that may be effected by massage i.e. those conditions listed above. Information exchanged during this and any future session is confidential between client and practitioner except upon written release by the client.*

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

*I understand that massage services are designed to be a health aid, and are in no way to take the place of a medical doctor's care.*

Client Signature \_\_\_\_\_ Date \_\_\_\_\_