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

Yes ☐ No ☐ Skin sensitivity
Yes ☐ No ☐ Allergies
Yes ☐ No ☐ Herpes I or II

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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_____