

# Michael Hayes, LMT

## Client Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment

\_\_\_\_\_ City State Zip

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

Are you under the care of a physician or other health care professional? \_\_\_\_\_

If so, why? \_\_\_\_\_

Current medication: \_\_\_\_\_

What is it for? \_\_\_\_\_

Do you have a heart condition? \_\_\_\_\_

Blood pressure:  Normal  High  Low

Have you had any operations? \_\_\_\_\_

Have you broken any bones? \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_

Sleep pattern: \_\_\_\_\_

Amount Type of sleep

Exercise: Type: \_\_\_\_\_ How often: \_\_\_\_\_

Type: \_\_\_\_\_ How often: \_\_\_\_\_

Type: \_\_\_\_\_ How often: \_\_\_\_\_

Type: \_\_\_\_\_ How often: \_\_\_\_\_

Type: \_\_\_\_\_ How often: \_\_\_\_\_

Type: \_\_\_\_\_ How often: \_\_\_\_\_

Any current problems: \_\_\_\_\_

Have you ever had a massage or shiatzu before? \_\_\_\_\_

How did you learn about us? \_\_\_\_\_

### 24-HOUR CANCELLATION POLICY