



Institute Of Russian Healing Arts

1693 Beacon St., Brookline, MA 02445
Phone 617-879-1880

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

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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 _____