A Caring Touch Massage Therapy
2519 N. McMullen Booth Road, Suite 201
Clearwater, Florida 33761

Robert Gambaro Jr., LMT
Phone: 727.726.8822

CLIENT INFORMATION

NAME: ______________________ SOCIAL SECURITY: ______________________

ADDRESS: ______________________ DATE OF BIRTH: ______________________

______________________ PHONE: ______________________

EMAIL: ______________________ SEX: Male Female

EMPLOYER: ______________________ JOB DESCRIPTION: ______________________

PHONE: ______________________ ______________________

PRIMARY DOCTOR: ______________________ PHONE: ______________________

ADDRESS: ______________________

LAST PHYSICAL: ______________________

Are you currently under the care of a physician? Yes No Please explain:

____

EMERGENCY CONTACT: ______________________ PHONE: ______________________

REFERRED BY: ______________________

Have you ever had a professional massage before? YES NO WHEN: ______________________

ADDITIONAL INFORMATION:

____

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Massage therapy is intended for the relief of muscle tension or spasm, reduction of stress, and to assist venous and lymphatic circulation. Massage therapists do not diagnose disease, presecribe medication or manipulate the spine. It is the client's responsibility to provide pertinent health information and to inform the therapist of any changes. Please be advised that some deep massage work and Neuromuscular Therapy may cause soreness and sometimes even bruising. Please immediately inform the therapist if any treatment is painful or excessive.
Payment terms: Services rendered are payable in full by cash, check or credit card at the time of service, inless advance special arrangements have been made with the massage therapist.
RELEASE: I understand and agree that massage services provided by this licensed massage therapist are provided pursuant to and in accorance with the laws of the State of Florida governing massage therapy and that full and complete medical history disclosure is essential in providing such therapy. I agree to hol harmless, release and indemnify this licensed massage therapist against any and all liability arising from the application of massage therapy. By signing this release I hereby delcare that I have provided this licensed massage therapist with all relevant information necessary for the proper application of massage therapy and I expressly give my permission for this licensed massage therapist to provide such therapy.

______________________ ______________________
SIGNATURE DATE

CONFIDENTIAL CASE HISTORY

Primary reason for your appointment? ______________________________

____

Please describe your areas of complaint, pain or tension. ______________________________

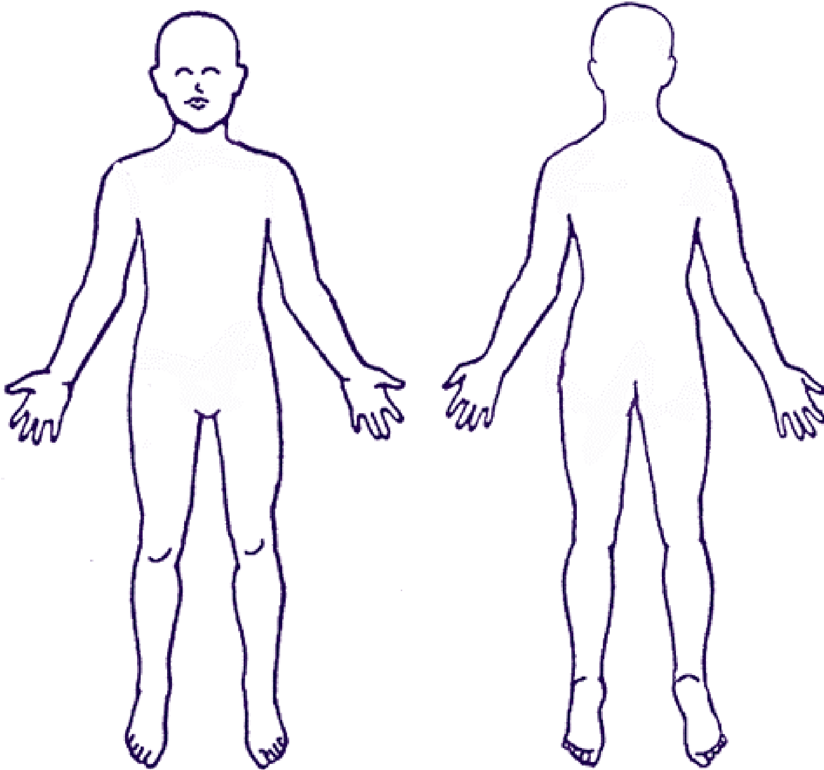
____

When did you first notice this? ______________________________

What brought it on? ______________________________

____

Please circle or mark any area of pain or concern



Have you recently been exposed to a contagious disease? Yes No

Do you have any other medical conditions I should be aware of?

____

Current medications?

____

Do you exercise? Yes No Describe:

____

____

Circle all you that pertains to you:

Meat Dairy Vegetables Fruit Alcohol Caffeine

Have you ever had any of the following conditions?

______	Injuries	______	Blood Pressure problems	______	Allergies
______	Spinal problems	______	Heart problems/conditions	______	Skin problems
______	Surgeries/Operations	______	Diabetes	______	Arthritis
______	Blood Clots	______	Abdominal pain	______	Stomach problems
______	Cancer	______	Varicose veins	______	Wear dentures
______	Kidney disease	______	Wear prosthetics	______	Wear contacts
______	Are you pregnant?	______	I am/was a smoker		

Do you have any concerns about your massage?

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