Date: _____

Massage Form

Client Information

Name: _____ DOB: _____

Occupation: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

How did you hear about us? (Circle one)

Our website Sign Brochure Event Women's Journal Google Facebook

Twitter Yelp Newsletter Family/Friend Gift Certificate Other

Referral:

_____

In case of EMERGENCY, please notify: _____

Phone: _____ Relationship: _____

Questions (Please circle and specify in space provided if applicable)

1. Do you prefer quiet massage or to engage in conversation? Quiet/Talking
2. Have you ever had massage therapy? Yes/No
3. What specific areas would you like to have worked on? _____
4. Are there any areas that should be avoided? Yes/No _____
5. Have you ever had surgery? Yes/No

   Date/type of last surgery _____
6. Do you have any long-term illnesses? Yes/No _____
7. Are you under a doctor's/chiropractor's care? Yes/No _____
8. Do you have headaches? Yes/No _____
9. Do you grind your teeth at night? Yes/No _____
10. Do you suffer from TMJ (jaw pain)? Yes/No _____
11. Do you suffer from allergies? Yes/No _____
12. Do you have any open sores/rashes? Yes/No _____
13. Do you have chronic pain/arthritis? Yes/No _____
14. Do you have varicose veins/blood clots? Yes/No _____
15. Do you have heart problems? Yes/No _____

Continue on Back!

16. Are you pregnant? Yes/No _____
17. Do you have diabetes? Yes/No _____
18. Do you have HIV/AIDS? Yes/No _____
19. Have you ever broken any bones? Yes/No _____
20. Have you suffered any sprains/strained muscles? Yes/No _____
21. Do you smoke? Yes/No _____
22. Do you have asthma? Yes/No _____
23. Are you sensitive to any oils or scents? Yes/No _____

I have completed this information to the best of my knowledge. I understand that massage services are designed to be a health aid and are in no way to take the place of a doctor's care. Information exchanged during any massage session is educational in nature and is intended to help the therapist to become more familiar and conscious of your health status. All information is private and confidential.

Signature: _____ Date: _____