

Name \_\_\_\_\_ Date \_\_\_\_\_

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

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
*Please circle the number you prefer to be contacted by regarding appointments*

Email \_\_\_\_\_ (To be used for appointment reminders and discounts)

Occupation \_\_\_\_\_ Hobbies \_\_\_\_\_

Referred By: web sign bench advertisement or Friend / Family if so, who \_\_\_\_\_

D/O/B \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Have you ever had a professional massage before? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, then when? \_\_\_\_\_

What would you like to achieve with today's visit? Relaxation \_\_\_\_\_ Health Maintenance \_\_\_\_\_ Pain Relief \_\_\_\_\_

**Are there any areas you would prefer NOT to have worked on?** (face, feet, knees, etc.) \_\_\_\_\_

**What type of pressure would you prefer?** Light \_\_\_\_\_ Moderate \_\_\_\_\_ Deep \_\_\_\_\_ Combination \_\_\_\_\_

Are you presently being treated by a Physician or other Medical Professional? Yes \_\_\_ No \_\_\_

If Yes Please list Name \_\_\_\_\_  
and reason for treatment \_\_\_\_\_

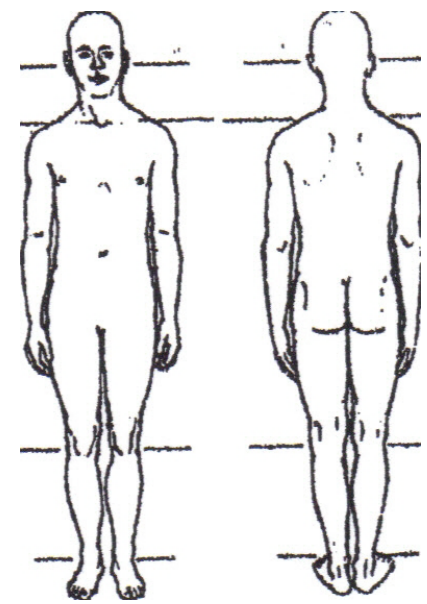
Are you allergic to any topical lubricants? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, which ones? \_\_\_\_\_

**Are there any factors in your life ( physical, mental, emotional) the therapist should be aware of?** \_\_\_\_\_

Please circle if you have or had any of the following. Please provide dates or other important information.

- Arthritis, Bursitis, Tendonitis \_\_\_\_\_
- Broken bones, strain, sprains \_\_\_\_\_
- Heart Conditions \_\_\_\_\_
- Varicose veins, blood clots \_\_\_\_\_
- Surgery \_\_\_\_\_
- High/Low blood pressure \_\_\_\_\_
- Allergies \_\_\_\_\_
- Skin rashes/conditions \_\_\_\_\_
- Numbness/Tingling \_\_\_\_\_
- Cancer \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Fibromyalgia \_\_\_\_\_
- Pregnancy (current or recent) \_\_\_\_\_
- Injuries/undiagnosed pain \_\_\_\_\_

**Circle areas of pain or tension below**



*If you would like to customize your treatment, please fill out the information below (OPTIONAL)*

During your treatment, would you rather feel: **warm cool no preference**

Would you prefer: **oils/lotion scented with aroma therapy no scent at all**

Type of music would you like to relax to: **piano oriental guitar Celtic ambient/new age flutes classical nature sounds** \*you may bring your own music if preferred.

Would you like Hot Packs used in your treatment? **Y \_\_\_ N \_\_\_**

Would you like stretching or range of motion incorporated into your massage? **Y \_\_\_ N \_\_\_**

After your massage, is your goal to feel : **calm and relaxed revived and refreshed OVER ->**