

Name: _____ Birth Date: _____

How did you hear about us? _____ Phone1: _____ cell / home / work

Address: _____ Phone2: _____ cell / home / work

City/State/Zip: _____ Have you had alcohol within 24 hours? [YES | NO]

Email: _____ We won't sell, trade or give your email away. We won't SPAM you.

Hobbies: _____

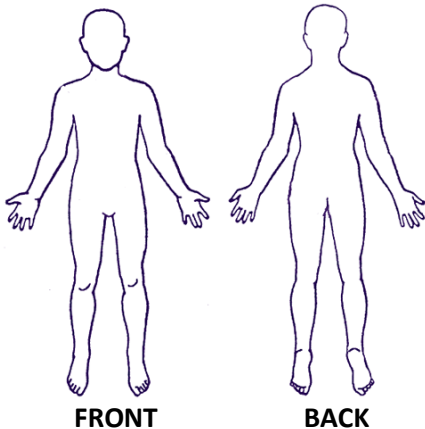
Do you sit for long hours at a work station, computer or car? (Explain) _____

What kind of stress do you have: _____

How is this affecting you? [] Muscle Tension [] Anxiety [] Insomnia [] Irritability [] _____

What are your goals for your massage session? _____

Indicate which areas bother you below:



HISTORY:

Have you been massaged before? [yes / no] Do you bruise easily? [yes / no]

I prefer the following pressure: [] Light [] Heavy [] Deep Trigger [] Unsure

Do you wear: [] Contacts [] Dentures [] Hearing Aid

Do you: [] Have a pacemaker [] Wear a patch [] Use prosthetics

Do you have difficulty lying on your back, side or stomach? _____

Do you have allergic reactions to any oil, lotion, ointment, gel or other? _____

Explain: _____

Are you under medical supervision? _____

Any medications? _____

Any surgeries or accidents w/in 24 months? _____

Are you or could you be pregnant? ___ Trimester# ___ Due: _____

Each time we will generally massage the following; which of the following would you like extra time spent on?

- __ Neck __ Low Back __ Legs __ Face __ Chest (excluding breast tissue)
- __ Arms __ Feet __ Stomach __ Hands __ Buttock __ Scalp __ Upper Back

Any area(s) you want us to exclude? _____

I have answered the above questions to the best of my ability. I acknowledge that massage therapy does not include medical diagnosis and that I should see an appropriate healthcare professional to diagnose and treat medical problems. I give my consent for the massage sessions.

Signature: _____ Date: _____

Parent if under 18: _____ Date: _____