

CONFIDENTIAL INFORMATION

Welcome. I want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your visit, please let me know.

(PLEASE PRINT)

Name _____ Phone: (H) _____ (W) _____

Street _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Male Female Marital Status _____

email address _____ referred by _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY? No Yes If yes, what type of massage have you experienced?

Deep Tissue Swedish Other(s) _____

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

- sunburn
- inflammation
- severe pain
- headache
- cuts, burns, bruises
- irritated skin rash
- poison ivy
- cold or flu

WHAT TYPE OF TOUCH DO YOU PREFER?

- Light/Meditative
- Heavy/Invigorating
- Deep/Trigger Point

HOW MANY HOURS PER WEEK DO YOU PARTICIPATE IN ACTIVITIES OR SPORTS?

- Less than one hour
- One to two hours
- Three to four hours
- Five or more hours

HOW MUCH WATER DO YOU DRINK PER DAY?

- Two to four glasses
- Five to seven glasses
- Eight or more glasses

WHAT ARE YOUR GOALS FOR MASSAGE?

- Relaxation
- Injury Rehabilitation
- High activity level, maintenance massage
- Other _____

WHAT IS YOUR MUSIC PREFERENCE?

You are welcome to look through my selection, or feel free to bring your own.

ARE THERE ANY OTHER HEALTH CONDITIONS I SHOULD BE AWARE OF? No Yes

If yes, please explain: _____

PLEASE READ AND INITIAL THE FOLLOWING, AND SIGN BELOW:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

Signature _____ Date _____

Shade in any area(s) where you are feeling discomfort:

