



Massage Therapy

NAME: _____ Referred by: _____

ADDRESS: _____ Date of Birth: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK OR CELL PHONE (circle one): _____

E-mail address: _____

What is/was your occupation? _____

Primary reason for appointment or areas of concern: _____

Have you ever had a professional massage before? Yes No

If Yes, would you say you like: Light Pressure Moderate Pressure Deep Pressure

Are you wearing dentures? Yes No

Are you wearing contact lenses? Yes No

Have you had alcohol in the last 8 hours? Yes No

Women: Are you pregnant? Yes No

Are you taking any medications? Yes No

If Yes, List: _____

Have you had or do you have any of the following? Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Back or neck discomfort or injuries |
| <input type="checkbox"/> Circulatory or Heart problems | <input type="checkbox"/> Car accident(s) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaw pain or injury |
| <input type="checkbox"/> Muscle cramping | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Skin conditions, irritations, lumps | <input type="checkbox"/> Dislocations, sprains or strains |
| <input type="checkbox"/> Fainting spells or Dizziness | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Numbness, tingling | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Herniated disks | <input type="checkbox"/> Allergies, skin sensitivities |

Please explain any marked items from above: _____

Do you have any other medical condition that your practitioner should be aware of before giving you a massage?

Please read before signing:

I understand that the purpose of this massage is for stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. This massage session is not a substitute for medical examinations and/or diagnosis. I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. I also understand that any illicit or sexually suggestive behavior, remarks, or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled appointment.

Signature: _____ Date: _____