**Name Phone** (\_\_\_\_) \_\_\_\_\_\_-\_\_ **DOB / /**

**Occupation**   **Gender Identity** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you are* ***(a)*** *under a physician’s care for any chronic/acute medical condition,* ***(b)*** *recovering from a recent injury or surgery, and/or* ***(c)*** *involved in a workman’s comp or accident case, please check with your physician prior to scheduling a massage and obtain written clearance/guidance, as necessary.*

**Is this your first massage EVER?** □ Yes □ No **What is your goal for today’s session?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any allergies?** □ Yes □ No If ‘Yes’, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History:** (Please check responses and make additional notes, as needed)

**Preferences:**

***Pressure:*** Light/ Medium /Firm ***Aromatherapy*:** □ Yes □ No ***Heat:*** □ Yes □ No ***Medium:*** Oil/Cream/Lotion

Do you frequently suffer from stress? □ Yes □ No

Do you have diabetes? □ Yes □ No

Do you experience frequent headaches? □ Yes □ No

If you have high blood pressure, are you taking high blood pressure medication? □ Yes □ No □ N/A

 If ‘Yes’, is it well-controlled? □ Yes □ No

Do you suffer from epilepsy/seizures? □ Yes □ No

Do you suffer from arthritis? □ Yes □ No

Do you suffer from joint swelling? □ Yes □ No

Do you have varicose veins? □ Yes □ No

Do you have any contagious diseases? □ Yes □ No

Do you have osteoporosis? □ Yes □ No

Do you bruise easily? □ Yes □ No

**Females:** Are you pregnant? □ Yes □ No □ N/A

Any broken bones in the past two years? □ Yes □ No

If ‘Yes’, please explain­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other injuries in the past two years? □ Yes □ No

If ‘Yes’, please explain­­­­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from back pain? □ Yes □ No

If ‘Yes’, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have numbness or stabbing pains? □ Yes □ No

If ‘Yes’, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently had surgery? □ Yes □ No If ‘Yes’, please explain­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have cardiac/circulatory problems? □ Yes □ No

Are you sensitive to touch or pressure in any area?

□ Yes □ No If ‘Yes’, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other medical condition(s) or medications I should know about?** □ Yes □ No If ‘Yes’, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you carry tension in a specific area?

□ Yes □ No If ‘Yes’, please specify ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE:** *We require 24Hr notice to schedule or cancel an appointment. Appointments canceled without 24 hour notice may be charged at the full rate.* **Client Initials:** \_\_\_\_\_\_\_\_\_\_\_\_