Massage Client Information

Name: _____ Phone #: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Email: _____

Date of Birth: _____ Occupation: _____

Referred by: _____

Emergency Contact: _____ Phone #: _____

General and Medical Information

Y N Have you ever had a professional massage? If yes, how often?

_____

Y N Are you pregnant? _____

Y N Do you wear contact lenses? _____

Y N Do you have high blood pressure?

If yes, is it under control? _____

Y N Do you suffer from seizure disorders or epilepsy? _____

_____

Y N Are you diabetic? If yes, is your diabetes under control? _____

Y N Have you broken any bones in the past two years? Which? _____

_____

Y N Do you have cardiac or circulatory problems? Please explain. _____

_____

Y N Have you ever had surgery? If yes, please explain. _____

_____

Y N Do you have any other medical conditions or injuries? _____

_____

_____

_____

Y N Are you currently taking any medications? What for? _____

_____

_____

_____