

Client Information Form

All information is held in the strictest confidence between you
(the client) and your massage therapist.

Name _____ Birthday _____
(If your address is the same as the last time you were in our salon please just write SAME AS BEFORE in those areas. Thank you.)

Address _____ City _____ State _____ Zip _____

Home# _____ Work# _____ Cell# _____

Email Address _____ Occupation _____

How did you hear of us or who referred you to us so we may give them a proper thank you and a client referral gift? _____

Please answer ALL questions:

Your therapist may ask you to elaborate on any of the following so please be as accurate as possible with all information.

Have you had a professional massage or body treatments (body exfoliation, body masques, etc) before? **Yes or No**

If **yes** how **long ago** was your last massage? _____

Do you have any skin issues/problems?----- **Yes or No**

Do you have blood clots or problems with blood clots in the past?----- **Yes or No**

Do you have blood pressure problems?----- **Yes or No**

Do you have any heart problems?----- **Yes or No**

Do you have allergies to oils, lotions, scents, detergents, nuts, seafood, seasonal allergies, etc.?
If **yes**, to what? _____ **Yes or No**

Do you have arthritis?----- **Yes or No**

Do you have any spinal problems?----- **Yes or No**

If **yes**, please explain _____

Are you pregnant or trying?-----**Yes or No**-----If **yes**, how far along are you? _____

We ask about the pregnancy due to the fact that we can not do massage if you are in the first trimester.

Are you under chiropractic care?----- **Yes or No**

Are you taking **any** medications?-----**Yes or No** ----- If **yes** please list them: _____

Please list surgeries, accidents, major illnesses, sports or exercise injuries and the dates they occurred: _____

Have you ever been diagnosed with **MRSA, chicken pox, measles, mumps, etc.** as a child /adult? (please circle)-----**Yes or No**

Please list **any and all other** medical issues/problems you have experienced: _____

Do you have any areas that need any special attention?---- **Yes or No**-----If **yes** please specify: _____

Please **circle the type of pressure** you would like your therapist to use during your massage today:

Light

Medium

Firm=Deep tissue (starts @ \$91.00)

I understand that the massage given to me by the massage therapist named below is for the purpose of stress reduction, relief from muscle tension, increasing circulation, or specific reasons listed above. I understand that the massage therapist does not diagnose illness, disease or any physical or mental disorder. Also, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand that massage therapy is not a substitute for medical examinations, medical care or diagnosis and that it is recommended that I work with my physician for any condition I might have.

****Because the massage therapist must be aware of all of my existing physical & medical conditions, as well as all medications; I have stated everything to the best of my knowledge. If you are under 18 years of age we will need a parents consent and their signature below your signature. I take it upon myself to keep the massage therapist updated on any changes.****

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____