

MESSAGE CLIENT INFORMATION

Name: _____ Date: _____
Home Phone: _____ Work Phone: _____ Birthdate: _____
Address: _____
Referred by: _____ Occupation: _____
In case of emergency: _____ Phone: _____

Primary reason for appointment: () Relaxation/Wellness () Chronic or Acute Pain
() Postural Balancing () Other _____

Area of complaint, pain or tension _____

Last Professional Massage _____ How did it go? _____

"I suffer from the following:"

- | | | |
|--|--|--|
| <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Sacroiliac or Low Back Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Tingling/Numbness in Arms or Hands |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Pinched Nerves in Back |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Tingling/Numbness in Legs or Feet |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> TMJ (Jaw Pain/Dysfunction/Clicking) |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bronchial Trouble | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Slipped, Herniated Disc | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Grating in Neck | |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> P.M.S. | |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nerves/Nervousness | |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Head Injury | |

In your massage, the areas that are worked may include the feet, legs, buttocks, back, neck, head, face, upper chest, abdomen, arms and hands. Your massage will be a therapeutic massage targeting any particular areas contributing to health problems, body pain or discomfort. Although we ensure your body is covered at all times, please indicate your preference to have any area omitted for any reason: _____

Is there anything you feel you need to say or ask before we begin? Any concerns? _____

Due to the fact that our business relies on scheduling of appointments and space availability, please be on time for your appointment. We will not be able to give you the full time booked should you arrive late. All cancellations must be made at least 24 hours in advance. Any cancellations after this time are subject to a missed appointment fee of \$40.

I realize that I am fully responsible for my body and well being at all times at the location where I receive the massage.

Signed: _____