restorative
MASSAGE

CONFIDENTIAL CLIENT INFORMATION – MASSAGE THERAPY

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone Number: (home) _____ (cell) _____ (work) _____

Email Address: _____ Would you like to receive occasional email updates? ☐ Yes ☐ No

How would you like to receive appointment reminders? ☐ Phone Call ☐ Phone Text ☐ Email ☐ None*
**Please note that failure to keep your appointment or cancel within 24 hours may result in additional fees. See Policies for details.*

Current Occupation/Employer: _____

How did you hear about us? ☐ Google ☐ Yelp ☐ Newspaper Ad ☐ Vehicle Advertisement
☐ From a friend, please provide his/her name: _____
☐ Other, please explain: _____

Have you ever received a professional massage therapy session? ☐ Yes ☐ No How recently? _____

What type of session did you receive? ☐ Swedish/Relaxation ☐ Deep Tissue ☐ I'm not sure
☐ Other, please explain: _____

What strength of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm ☐ I'm not sure

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THE FOLLOWING REQUIRED INFORMATION MUST BE COMPLETED IN ITS ENTIRETY, HONESTLY AND TO THE BEST OF YOUR KNOWLEDGE:

Please list all medications (over-the-counter *and* prescribed) and supplements that you are currently taking:

_____

_____

Please list all allergies or sensitivities, including smells: _____

_____

Do you have or have you recently been in contact with any contagious illnesses or infections, including skin conditions:
☐ No ☐ Yes, please explain: _____

Have you ingested any alcohol, illegal substances, or anti-inflammatory medication in the last 24 hours? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

What is your typical daily intake of:

Water?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Caffeine?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Salt?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Sugar?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Cigarettes?	☐ None	☐ Light	☐ Moderate	☐ Heavy

How many hours of sleep to do you usually get each night? _____

Do you exercise and/or stretch on a regular basis? ☐ No ☐ Yes How often and what type of workout? _____

_____

PLEASE CONTINUE ON THE BACK OF THIS PAGE.

Please mark the box(es) next to any health condition below that applies to you now or has applied to you in the past:

- ☐ Anemia
- ☐ Anxiety/Panic Attacks issues
- ☐ Arthritis
- ☐ Arm/elbow/wrist pain
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood clots
- ☐ Heart Attack
- ☐ Bone disease or disorder
- ☐ Broken bones
- ☐ Bruising easily
- ☐ Bursitis
- ☐ Cancer
- ☐ Cardiac problems
- ☐ Circulatory Problems
- ☐ Claustrophobia
- ☐ Constipation
- ☐ Diabetes
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Hip/leg pain
- ☐ HIV/Aids
- ☐ Jaw pain
- ☐ Knee pain
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Neck/Shoulder Pain
- ☐ Numbness or tingling in specific areas
- ☐ Post-Traumatic Stress Disorder
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Seizures
- ☐ Stroke
- ☐ Surgery
- ☐ Varicose Veins
- ☐ Other conditions not listed (*please list and describe in the space below*)

Further explanation for any of the above conditions: _____

_____

_____

_____

_____

Do you have any of the following occurring today:

- ☐ Cold/flu/fever
- ☐ Numbness/Tingling
- ☐ Cuts, bruises, or burns
- ☐ Skin rash
- ☐ Headache
- ☐ Severe Pain
- ☐ Inflammation
- ☐ Sunburn

Please use the illustration to indicate with an "X" any areas of pain, discomfort, or tightness. Please indicate with a "T" any areas that are ticklish. Use the space below to further explain your markings: _____

_____

_____

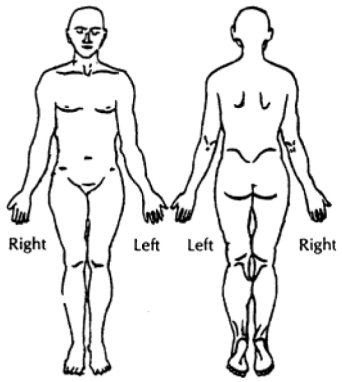
_____

_____

_____

_____

_____



By providing my signature below, I confirm that the information recorded above is complete, accurate, and honest to the best of my knowledge. I understand that massage therapy is not a replacement for medical treatment, and that the therapist may only perform treatments within his or her scope of practice and level of comfort. Anything said during this session shall not be regarded as medical advice, treatment, diagnosis, or prescription. I understand that the therapist may refuse service at any time for any reason, and that certain medical issues may contraindicate massage services and will be referred to a medical professional. I understand that it is my responsibility to inform the massage therapist of any changes to my medical health profile and that the therapist will not be held liable for anything resulting from my failure to do so. I agree that I have been given sufficient opportunity to ask questions and make specific requests in order to make my treatment time as comfortable as possible. I have also read and will abide by all policies and client expectations that may be listed separately from this document.

Client Signature: _____ **Date:** _____

(☐ *Check here if you are signing as the legal guardian for a minor under the age of 18.*)

Therapist Signature: _____ **Date:** _____