

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Permission given to call in an emergency

Medical Conditions, circle if applicable

Blood Clots

Diabetes

Heart Condition

Aneurysm

Osteoporosis

Ongoing Infections

High/Low Blood Pressure

Osteoarthritis

Varicose Veins

Thyroid Problems

Immune Deficiencies

Foot/Toe Fungus

Cancer: In treatment? Y N

Skin that easily bruises or tears

Other Conditions Not Listed: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Surgeries/ Date: \_\_\_\_\_

Injuries, Accidents/ Date: \_\_\_\_\_

Is this your first massage? Y N

What kind of pressure do you like? Light \_\_\_ Medium \_\_\_ Firm \_\_\_ Don't know \_\_\_

Common trouble spots: \_\_\_\_\_

Current areas of pain, tension, or soreness: \_\_\_\_\_

Pregnant? Y N

Are vaccinated against COVID 19: Y N

Dates: \_\_\_\_\_

Sign: \_\_\_\_\_

Date : \_\_\_\_\_