Name: ______________________________________ Birthday: ___________________

Address: ________________________________________ City/State/Zip: _________________________

Mobile Phone: ______________________________ Phone Carrier: ______________________

Email Address _________________________________________________________________

Reminder: Email/ Text/ Both Referred by: ___________________________________

Would you like to be added to our email list for discounts & specials? ________________________

General and Medical Information

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

Y N Are you pregnant? If yes, how far along are you?____________________________________

Y N Are you sensitive to touch/pressure in any area?(ticklish?)_____________________________

Y N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? If yes, please list:

_________________________________________________________________________________

List of current medications and reasons:________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

List of surgeries (type and date):_______________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Indicate Areas of Pain/Tension

On a scale from 1-10, 10= highest, rate your levels

Stress _____Pain _____Energy_____

How did your symptoms begin and when did they start?

_______________________________________

_______________________________________

What have you done for relief?

_______________________________________

Is the condition getting better/worse?

_______________________________________

Please check all that apply

☐Skin condition- rash, warts, hives, skin cancer, other___________________________________

☐Lymphatic condition- swollen gland, nasal congestion, lymph edema

☐Joint problems/stiffness- arthritis, sacroiliac problems, TMJ, other

☐Bone conditions- osteoporosis, fracture, other________________________________________

☐Headaches

☐Recent injury or accident- whiplash, sprain, bruise,

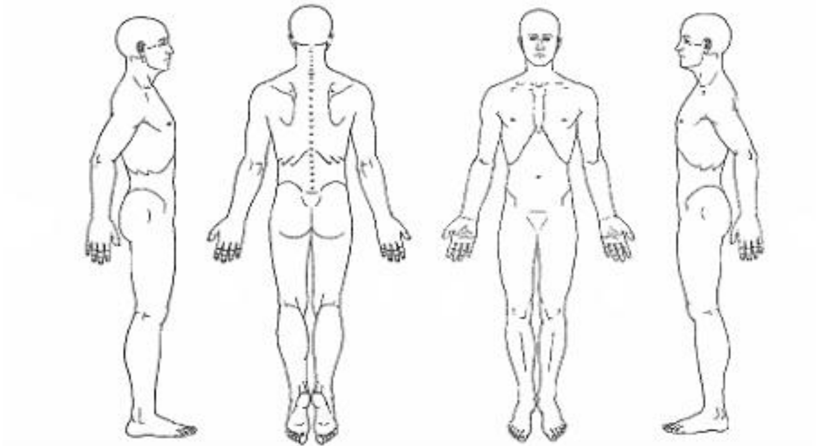
other________________________________________

☐Circulatory condition- high blood pressure, varicose veins, blood clots

☐Numbness/Tingling, Sciatica

☐Tendonitis, Bursitis

☐Diabetes



Please mark in the diagram above any areas where you have pain or discomfort.