



Name: _____ Birthday: _____ Today's Date _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Occupation: _____ Male ___ / Female ___ / Other ___

If you are an expecting mother, please notify the front desk prior to your massage.

How did you hear about Massage Studio? Google Yelp Facebook Instagram Walk By/Drive By
 YouTube Referred By _____ Other _____

Are you here for a specific accident or doctor's referral? _____

If yes, explain _____

Where on your body do you feel pain, tension, discomfort? _____

Have you received a massage before? _____ Date of last massage _____

How many ounces of water do you drink on average per day? _____

Are you on any medications? (aspirin, ibuprofen, herbs, prescriptions, supplements, etc)?

Have you had any accidents or surgeries in the last 5 years? If yes, explain _____

Please list all forms and frequency of stress reduction activities, hobbies, exercise, or sports participation.

Please mark (x) for all conditions that presently apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches, migraines | <input type="checkbox"/> Allergies, sensitivities | <input type="checkbox"/> Abdominal or digestive problems |
| <input type="checkbox"/> Injuries to face and head | <input type="checkbox"/> Hernia | <input type="checkbox"/> Jaw pain, TMJ problems |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Asthma or lung conditions |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Constipation or diarrhea |
| <input type="checkbox"/> Cancer or tumors | <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> Birth control, IUD |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Spinal column disorders | <input type="checkbox"/> Heart, circulatory problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscle, bone injuries | <input type="checkbox"/> Arthritis/ osteoarthritis/tendonitis |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Rashes, athlete's foot |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Varicose veins/blood clots | <input type="checkbox"/> Other conditions _____ |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Bumps/moles location _____ |
| <input type="checkbox"/> Tension, stress | <input type="checkbox"/> Depression/fatigue | |

Please explain any areas noted above: _____

Areas to avoid due to pain or injury:

OVER →

All massages are personalized just for you with complimentary amenities. Please customize your visit below...

Select the Aromatherapy Scent you would like during your massage:

Lemongrass Eucalyptus Lavender None

Select a preference of music during your massage:

Spa Nature Lounge Jazz Classical Vocals Seasonal

What type of massage pressure do you prefer?

Light Pressure Medium Pressure | Firm Pressure Very Firm Pressure
[Swedish massage] | [Deep Tissue massage in one or more areas]

Would you like face and scalp massage?

Yes No Therapist Discretion

What type of massage product do you prefer your therapist to use?

Massage Cream Massage Oil CBD Oil *\$10 upgrade. Inform LMT prior to service

Are you comfortable with glute work?

Yes No Therapist Discretion

Would you like pain relieving products (for sore muscles, joints, back pain, etc.)?

Yes No Therapist Discretion

Would you prefer your table heated? Yes No

In order to personalize your experience, please list any other requests you may have:

I, (print your name) _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Name (signature): _____ **Date:** _____