Client Health History and Massage Information

Name _____ Date _____

Phone _____ Email _____

Send me reminders about my appointments via ___Text ___Call ___Email ___No Reminders

If you DO NOT want to receive the email newsletter, check here ___

I was referred by _____

In case of emergency, please call (name) _____

at (number) _____

Have you had a professional massage before? _____

If so, how often do you receive massage? _____

What kind of pressure do you prefer? ___Gentle ___Medium ___Firm

Do you prefer ___Oil ___Lotion ___No Preference

Do you have allergies or aversions to any essential oils? _____

Is there a particular type of music you prefer during a session?_____

What are your specific goals for the session today? _____

_____

_____

Are there any areas you would like to focus on? _____

_____

Are there any areas you do NOT want to receive massage? _____

_____

Are you currently taking pain medication or blood thinners? _____

Are you pregnant? ___Yes ___No

How far along? _____

Any complications? _____

Are you wearing ____Dentures ___Hairpiece ___Hearing Aid

Is there anything else you would like me to know? _____

_____