CUSTOMER INFORMATION

Name: ____________________________________ DOB: ________________ Gender: *M / F*

Add: ________________________________ City____________ State_____ Zip Code ______

Home Phone: ________________ Cell: __________________ Cell Carrier: ______________

Email: ___________________________________ Occupation: _________________________

What is your preferred contact method? Please check all that apply:

☐ Email ☐ Text Message ☐ Phone Call

***You will automatically receive appointment notifications, reminders and confirmations through email and cell phone. You will also be able to check in online with the cell phone number you provide.*

Emergency Contact: ___________________________ Relationship to you ________________

Phone: _______________________ How did you hear about us? ________________________

Have you ever had a professional massage before? *Yes / No* How Recently? ________________

Primary Reason for massage *(Circle all that apply)*:

Manage Pain Relieve Discomfort Maintain Health Reduce Stress

Simply Relax Other: ____

~ PLEASE COMPLETE OTHER SIDE ~

Please Circle all that Apply

Yes / No Do you frequently suffer from stress?

Yes / No Do you have diabetes? Any pumps? ______________________________

Yes / No Do you experience frequent headaches?

Yes / No Are you pregnant? If so, how far along? ___________________________

Yes / No Do you suffer from arthritis?

Yes / No Are you wearing contact lenses?

Yes / No Do you have high blood pressure?

Yes / No Do you suffer from epilepsy or seizures?

Yes / No Do you have varicose veins?

Yes / No Do you have osteoporosis?

Yes / No Do you bruise easily?

Yes / No Have you had any broken bones in the past two years?

Yes / No Have you had any accidents or suffered any injuries in the past two years?

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Yes / No Do you have numbness or stabbing pain anywhere? __________________

Yes / No Do you have any tension or soreness in a specific area? _______________

Yes / No Are you sensitive to pressure or touch in any area? __________________

Yes / No Do you have any allergies, specifically topical? _____________________

Yes / No Do you have a pacemaker? What year? ____________________________

Yes / No Do you have any other medical conditions that your therapist know about?

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Yes / No Are you taking any medications? (Pumps, prescription or over the counter)

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