ROCKWALL MEDICAL MASSAGE

CUSTOMER INFORMATION

Name: _____ DOB: _____ Gender: *M / F*

Add: _____ City_____ State_____ Zip Code _____

Home Phone: _____ Cell: _____ Occupation: _____

Email:_____

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 ~

ROCKWALL MEDICAL MASSAGE

Please Circle all that Apply

Yes / No Do you experience frequent headaches?

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 Do you have any subdermal piercings?

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

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

Yes / No Do you have a pacemaker or other device? What year?

_____

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

_____

_____

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

_____

_____

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

List of current medications (Pumps, prescription or over the counter):

_____

_____

Areas of pain/tension:_____

_____

Areas to be avoided_____

_____