MASSAGE STUDIO

Name: _____ Birthday: _____

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

Cell Phone: _____ Email: _____

Occupation: _____Male _____ / Female _____

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

How did you hear about Massage Studio? ☐ Google ☐ Yelp ☐ Direct Mail ☐ Walk By/Drive By ☐ Billboard
☐ Refered 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.

__ headaches, migraines	__ allergies, senstivites	__ abdominal or digestive problems
__ injuries to face and head	__ hernia	__ jaw pain, TMJ problems
__ sinus problems	__ easy bruising	__ asthma or lung conditions
__ numbness or tingling	__ sleep difficulties	__ constipation or diarrhea
__ cancer or tumors	__ muscle or joint pain	__ birth control, IUD
__ blood clots	__ spinal column disorders	__ heart, circulatory problems
__ diabetes	__ muscle, bone injuries	__ arthritis/ osteoarthritis/tendonitis
__ pregnancy	__ carpal tunnel syndrome	__ rashes, athletes foot
__ dry skin	__varicose veins/blood clots	__ other conditions _____
__ high/low blood pressure	__ epilepsy	__ bumps/moles location _____
__ tension, stress	__ depression/fatigue	

Please explain any areas noted above: _____

_____ 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

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? _____

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: _____