CLIENT PROFILE

Name: _____ **Date** _____

Address: _____

Phone: _____ **DOB** (*mm/dd/yy*): _____ **Occupation:** _____

Please review the following list and check anything that might be relevant to you:

- □ Abdominal Pain
- □ Allergies (Oils, Nuts, Fragrances)
- □ Arthritis
- □ Auto-immune Condition
- □ Back Pain: □ Upper □Mid □ Lower
- □ Broken Bones
- □ Cancer
- □ Cardiac/Circulatory Condition
- □ Carpal Tunnel Syndrome
- □ Chronic Pain: _____
- □ Constipation/Diarrhea
- □ Contact Lenses
- □ Decreased Range of Motion
- □ Depression
- □ Diabetes
- □ Diverticulitis
- □ Fibromyalgia
- □ Headache
- □ Herniated Disk
- □ High Blood Pressure
- □ Injury: _____
- □ Insomnia
- □ Muscle Strain/Sprain
- □ Numbness: _____
- □ Scoliosis
- □ Seizures
- □ Surgery: _____
- □ Skin Condition: _____
- □ TMJ
- □ Varicose Veins
- □ Whiplash
- □ Other: _____

□ Are you seeing a health care professional? _____

□ Are you currently taking any medications? (including aspirin, ibuprofen …)

_____

□ List Areas to be Avoided during repeat Sessions: _____

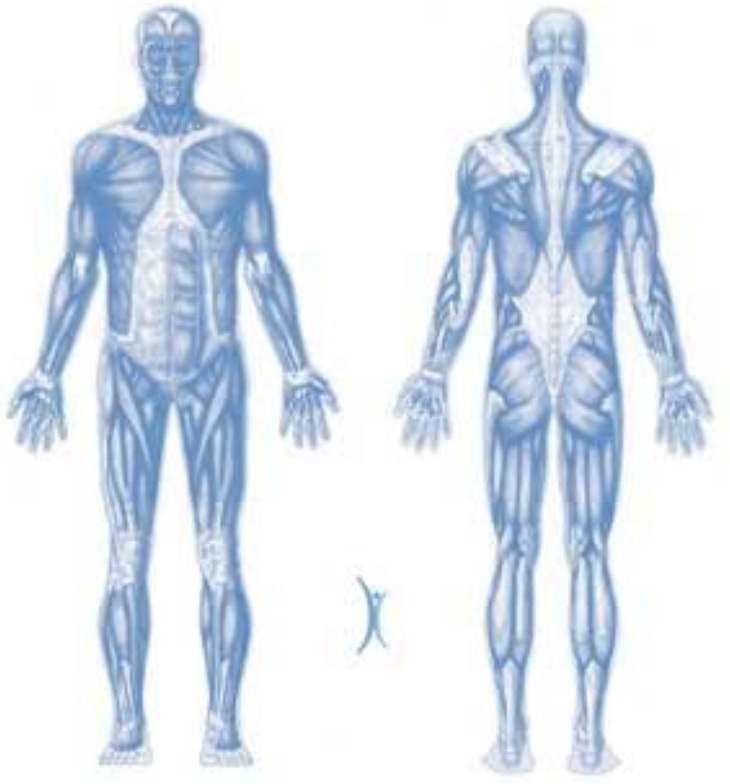
□ Where do you usually hold tension? _____

□ Preferred Level of Pressure: □ Light □ Medium □ Medium/Deep □ Deep

□ How did you hear about us? _____

□ Are you interested in promotional offers? □ Yes _____ □ No

(email)



On the diagrams, please indicate any areas in which you are currently feeling discomfort.
I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.

_____

Client's Signature

CLIENT FEEDBACK

We value your Feedback. Please take a moment to help us improve your next session

My favorite moment during the session was:

Something I wished had been different was:

Additional comments:

*****Partners in Healing, Wellness and General Relaxation *****