



CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Practitioner's Initials: _____

General Information

First Name: _____ Last Name: _____ Date of Birth: ___/___/___

Address: _____ Apt: _____ City: _____ Zip: _____ Male **OR** Female

Phone: (Cell) (_____) _____ Cell Service Provider: _____ (ex: AT&T)

Email: _____

Employer: _____ Occupation: _____

Emergency contact: _____

Phone: (_____) _____

Relationship: _____

Who Referred You? _____

Groupon Redemption Code

(8-digit number OR beginning in NY1 OR NY2)

____/____/____/____/____/____/____/____

Enhance Your Session with One of the Following

Prices	Add-on Services	Benefits	✓
\$10	Sugar Foot Scrub	Soothe tired feet and alleviate dry skin to refresh, revive and reveal a healthy glow.	
\$35	Herbal Steam Detox <i>(Requires additional 25 min)</i>	Helps with: Skin care, cellulite reduction, deep relaxation, joint pain relief and detox.	
\$10	Hand/ Foot Paraffin	Soothes and repairs cracked and dry skin, while moisturizing your hands or feet.	
\$10	Aroma Therapy	Relieve stress, inflammation, and pain with essential oils from herbs, flowers and fruits.	

COMPLETE OTHER SIDE

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Circle any specific areas you would like the massage therapist to concentrate on during your session:



Medical Background

1. Is this your first professional massage? ___ Yes ___ No	10. Area(s) you would like your therapist to avoid : _____
2. If no, how frequently do you get massage? _____	11. Area(s) you would like your therapist to focus on: _____
3. What do you hope to accomplish from today's massage? _____	12. Pressure Preferred: (Circle one) Light Medium Firm
4. Are you aware of any tension holding spots in your body? ___ Yes ___ No If yes, where: _____	13. 1-5 with 5 being the most what is your pain level today? _____
5. Do you have any sensitivity to heat or cold? ___ Yes ___ No	14. 1-5 with 5 being the most what is your stress level today? _____
6. Do you have any allergies or sensitivity to smells, oils, lotions, or ointments? ___ Yes ___ No	15. Are you Pregnant? ___ Yes ___ No How many months? _____
7. Do you have any skin conditions or rashes? ___ Yes ___ No	16. Do you have any difficulty lying on your front, back or side? ___ Yes ___ No
8. Any recent surgeries or broken bones? ___ Yes ___ No If yes, what kind or where: _____	17. Do you see a chiropractor? ___ Yes ___ No
9. Do you have any chronic, ongoing pain that you deal with on a regular basis? ___ Yes ___ No	18. Do you wear contact lenses? ___ Yes ___ No

Draping will be used during your session- only the area being worked on will be uncovered.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours' notice (medical emergencies excluded) will be charged 50% and complete NO-SHOW will be charged 100%.

Signature: _____ **Date:** _____