Massage Information Form

Personal Information

Name: ______________________ Phone (day): ______________ (evening) ______________

Address: ______________________ City/State/Zip: ______________________ DOB ________

Occupation: ______________________ Employer ______________________

Email: ______________________ Primary Physician ______________________

Emergency Contact ______________________ Relationship ______________ Phone ______________

How did you hear about us? ____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: ______________________

____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? ______________________

Any high risk factors? ______________________

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain ______________________

What makes it better? ______________________

____

What makes it worse? ______________________

____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: ______________________

Please indicate any of the following that apply to you.

☐ Asthma	☐ PMS
☐ Arthritis	☐ Chronic Neck/Back Pain
☐ Eczema	☐ High/Low Blood Pressure
☐ Diabetes	☐ Digestive Disorders
☐ Cancer	☐ Infectious Disease
☐ Carpal Tunnel	☐ Migraines
☐ Varicose Veins	☐ Epilepsy
☐ Heart Disease	☐ Edema
☐ Anemia	☐ Ulcer

Explain any conditions you have marked above:

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Please provide any other information of which you would like us to be aware:

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Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other ______________________

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain? ______________________

Are there any areas (feet, face, abdomen, etc.) that you do not want massaged? ☐ yes ☐ no

Please explain? ______________________

What are your goals for this treatment session?

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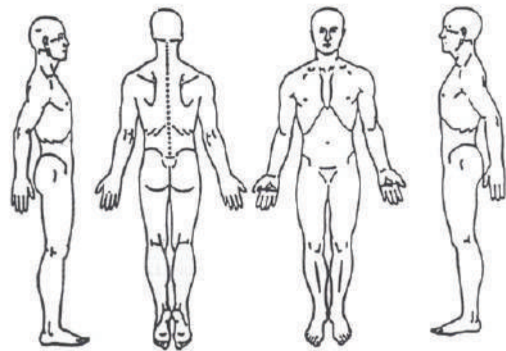
Please circle any areas of discomfort



We appreciate your understanding that Skin Sense may use the information in this form to provide treatments and products to you. We know you will understand the importance of letting us know if any of the information you provide to us in this form or otherwise changes in any way. We will rely on you to inform us of those changes when they occur. We appreciate also your agreement by signing below that Skin Sense cannot be liable for the outcome or effects of its services and products beyond the amount paid for them.

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Client Signature

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Date