



Massage Therapy Client Information Form

Name _____ Date _____
 Home Phone (____) _____ Mobile Phone (____) _____
 Email _____ May we contact you via email? Y ___ N ___
 Address _____
 City _____ State _____ Zip _____
 Birth Date _____ Male/Female _____ Pregnant? Y / N
 Occupation _____ Employer _____
 Physician's Name _____ Phone (____) _____
 Emergency Contact _____ Phone (____) _____
 Primary reason for appointment? _____
 Exercise Regularly?: Y / N _____ Have you ever had a professional massage? Y / N _____

Please indicate if you a history of any of the following:

- | | |
|---|--|
| <input type="checkbox"/> allergies/sensitivities | <input type="checkbox"/> dental bridges/braces |
| <input type="checkbox"/> digestive/abdominal problems | <input type="checkbox"/> depression, panic disorder, other psych condition |
| <input type="checkbox"/> asthma or lung conditions | <input type="checkbox"/> diverticulitis |
| <input type="checkbox"/> arthritis, tendonitis | <input type="checkbox"/> headaches, migraines |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> heart conditions |
| <input type="checkbox"/> birth control/IUD | <input type="checkbox"/> back problems |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> broken/dislocated bones | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> muscle strain/sprain |
| <input type="checkbox"/> cancer, tumors | <input type="checkbox"/> muscle or joint pain |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> constipation/diarrhea | <input type="checkbox"/> rashes/athlete's foot |
| <input type="checkbox"/> auto-immune condition* | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> seizures |
| <input type="checkbox"/> hepatitis (A, B, C, other) | <input type="checkbox"/> sinus problems |
| <input type="checkbox"/> hernia | <input type="checkbox"/> tension/stress |
| <input type="checkbox"/> hearing problems/deafness | <input type="checkbox"/> depression |
| <input type="checkbox"/> skin conditions | <input type="checkbox"/> sleep difficulties |
| <input type="checkbox"/> stroke | <input type="checkbox"/> whiplash |
| <input type="checkbox"/> surgery | <input type="checkbox"/> vision problems/contact lenses |
| <input type="checkbox"/> jaw pain/TMJ disorder | <input type="checkbox"/> chemical dependency (alcohol, drugs) |
| <input type="checkbox"/> numbness or tingling | |
| <input type="checkbox"/> varicose veins | |

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

Explain any areas noted: _____

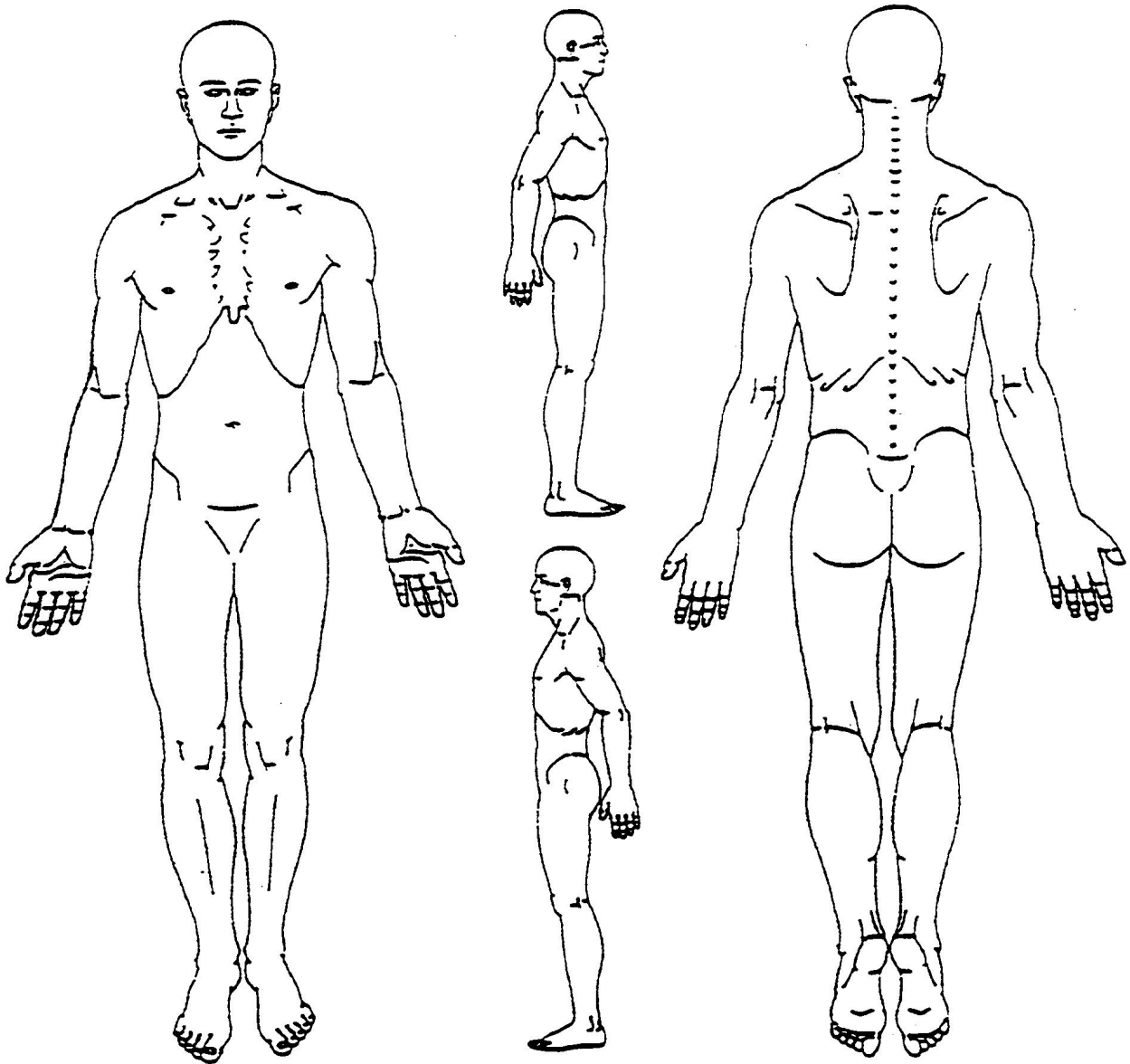
Current medication (including aspirin, ibuprofen, herbs, vitamins, etc.): _____

Surgeries: _____

Accidents: _____

Please list all forms and frequency of stress-reduction activities, hobbies, exercise or sports participation: _____

Please circle the areas giving you trouble:



Additional comments:



Premier Bodyworks Massage Therapy Cancellation Agreement

I understand that twenty four (24) hours notice is required to cancel my appointment for massage. In the event 24 hour notice is not given to cancel the appointment, I agree to pay the normal massage fee due for the missed appointment. I will not be charged as long as advanced notice is given.

Appointments:

- Patients should arrive 10 minutes prior to their scheduled appointment time.
- Patients are expected to have used the restroom and be ready for their appointment at their scheduled time.

Current fees:

- 30 Minute Massage - \$35.00
- 60 Minute Massage - \$65.00
- 90 Minute Massage - \$90.00

**Thank you for choosing Premier Bodyworks Massage Therapy
for your massage services.**

Signature: _____ **Date:** _____