Massage Information Form

Today's Date:_____

Name:_____ Birth Date:_____

Is this your first professional massage? Yes No If no, how often do you get a massage?_____

Are you aware of any tension spots in your body, or are you experiencing any pain?_____

_____

Do you perform any repetitive movement in your work, sports, or hobby, or do you sit or stand for long hours?
Please explain:_____

_____

Describe any surgeries, hospitalizations, accidents or injuries you have had in the past two years:_____

_____

Do you have any chronic or ongoing pain? Please explain:_____

_____

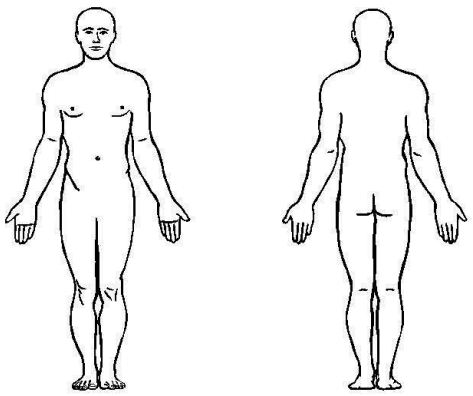
Do you have any sensitivity to heat or cold, or are you sensitive to lotions or oils?_____

Is there anything else that you would like your therapist to know about your session today?_____

_____

Please indicate where you are experiencing pain, stiffness or numbness on the drawing below.

P = Pain S = Stiffness N = Numbness T=Tension



Signature:_____ Date:_____ Time:_____