**Personal Information**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:  \_\_\_\_\_\_\_\_\_\_\_         Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Day): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (Evening): \_\_\_\_\_\_\_\_\_\_\_\_\_

  Email:   
Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Date of Initial Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Massage Background**

1. Have you had a massage before?  
   Yes: No:  
   If yes, how often do you receive massage therapy? 
2. Do you have any difficulty lying on your front, back, or side?  
   Yes: No:  
   If yes, please explain: 
3. Do you have any allergies to oils, lotions, or ointments?  
   Yes: No:  
   If yes, please explain: 
4. Do you have sensitive skin?  
   Yes: No:
5. Are you wearing any of the following:   
   Contact Lenses  
   Dentures  
   Hearing Aid
6. Do you sit for long hours at a workstation, computer, or while driving?  
   Yes: No:  
   If yes, please explain: 
7. Do you perform any repetitive movement in your work, sports, or hobby?  
   Yes: No:  
   If yes, please explain: 
8. Do you experience stress in your work, family, or other aspects of your life?  
   Yes: No:  
   If yes, how do you think it has affected your heath:   
   Muscle tension  
   Anxiety  
   Insomnia  
   Irritability  
   Other: 
9. Do you experience stress in your work, family, or other aspects of your life?  
   Yes: No:  
   If yes, please explain: 
10. Is there a particular area of the body where you are experiencing tension, stiffness, or pain?  
    Yes: No:  
    If yes, please identify: 
11. Do you have any particular goals in mind for your massage sessions?  
    Yes: No:  
    If yes, please explain: 
12. Select any areas you would like the massage therapist to concentrate on during the session:  
    Scalp  
    Neck  
    Shoulder (Right)  
    Shoulder (Left)  
    Biceps (Right)  
    Biceps (Left)  
    Triceps (Right)  
    Triceps (Left)  
    Hand (Right)  
    Hand(Left)  
    Upper Chest (Right)  
    Upper Chest (Left)  
    Upper Back (Right)  
    Upper Back (Left)  
    Abdomen  
    Lower Back  
    Buttocks  
    Thigh (Right)  
    Thigh (Left)  
    Calf (Right)  
    Calf (Left)  
    Foot (Right)  
    Foot(Left)