

# Tranquility Massage

## & Wellness Center

### Massage Client Information and Consultation Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Reason For Appointment: \_\_\_\_\_

Have you had a professional massage in the past? YES NO If "yes", How long ago? \_\_\_\_\_

List Current Medications: \_\_\_\_\_

List any Allergies: \_\_\_\_\_

**Place a check mark next to any of the following that may apply:**

\_\_\_ *Frequent Headaches*

\_\_\_ *Injuries within 12 months*

\_\_\_ *Arthritis*

\_\_\_ *Diabetes*

\_\_\_ *Varicose Veins*

\_\_\_ *Contagious Disease or Illness*

\_\_\_ *Osteoporosis*

\_\_\_ *Allergies*

\_\_\_ *Fibromyalgia/Chronic Fatigue*

\_\_\_ *Scoliosis*

\_\_\_ *Chronic Neck or Back Pain*

\_\_\_ *Inflammation or swelling*

\_\_\_ *Blood Clots/ Phlebitis*

\_\_\_ *Cardiac or Pulmonary Issues*

\_\_\_ *Cancer (currently or within the last 12 months)*

\_\_\_ *Injuries within 12 months*

\_\_\_ *High Blood Pressure*

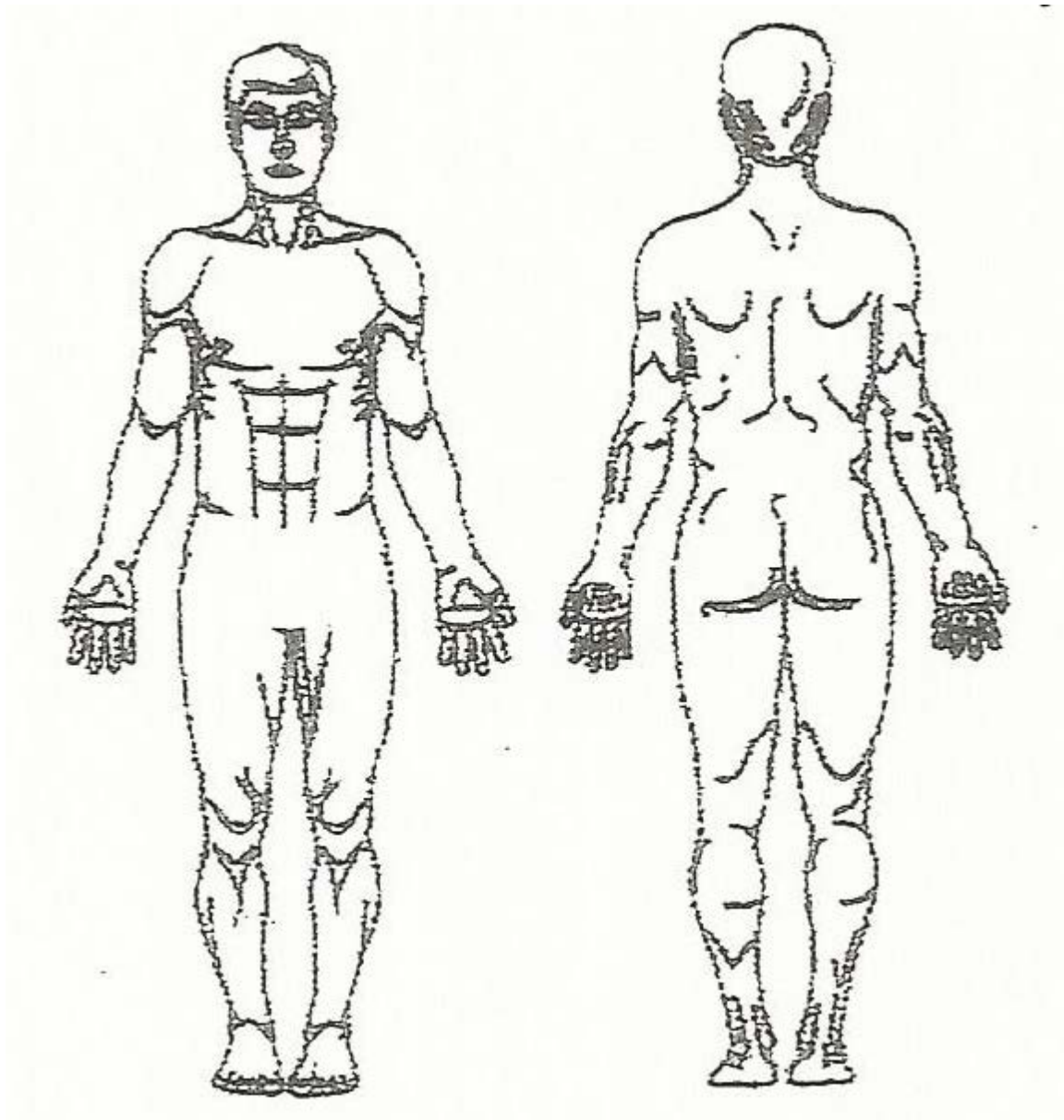
*Other Medical Conditions not listed above* \_\_\_\_\_

Pressure Type to be used: Light Medium Deep (please circle one)

\*Pressure type can be modified at any time before or during massage. Please let me know your preference. This is your massage and only you can tell me if it's too light or too heavy... Thank you.

What outcome do you Expect or Wish to Achieve from this Massage/Bodywork Session? \_\_\_\_\_ -  
\_\_\_\_\_.

On this diagram Please **CIRCLE** the areas of the body that you feel need the most attention in the massage session, and place an "X" over the areas that you wish to have avoided.



**Please Read The Following Information and Sign Where Indicated**

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. There are certain medical conditions in which receiving a massage may not be appropriate. In those cases a referral from a physician may be required prior to services being provided. Massage/bodywork is not a substitute for medical attention received by a medical specialist. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure/strokes may be adjusted. In addition, if I am uncomfortable for any reason, I may ask that the session be stopped immediately.

Draping will always be used during the massage/bodywork sessions. No breast massage shall be done without written consent of the client and therapist. Any illicit or sexually suggestive remarks or advances made by me (the client) will result in the immediate termination of the session.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**FOR THERAPIST USE ONLY:**

Services to be performed today: \_\_\_\_\_

Type of Massage/Bodywork Session: \_\_\_\_\_

**Therapist's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Soap Notes Attached see page 4