

Adriana's Massage

2717 E. Southlake Blvd. Ste 160, Southlake TX 76092 (817) 781-6757

CLIENT INFORMATION FORM

NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE (H) _____ CELL _____

OCCUPATION _____ E-MAIL _____

IN CASE OF EMERGENCY PLEASE NOTIFY _____

PLEASE CHECK ALL THAT APPLY:		PLEASE CHECK:	Y	N	MASSAGE PREFERENCES AREAS TO CONCENTRATE/ AREAS TO AVOID		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Migraine/Headache	Are you currently pregnant?				Concentrate	Avoid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	Have you had any recent surgery?			Back		
<input type="checkbox"/> Cancer	<input type="checkbox"/> Tense Muscles	Have you had any recent injury?			Shoulders/Neck		
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Infection	Participate in Sports?			Arms		
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Skin Disorder	Did you receive massage before?			Legs		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Contacts	Contraindications (Please list)			Head		
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Spinal Injury	1.			Buttocks		
<input type="checkbox"/> Thyroids	<input type="checkbox"/> Cosmetic Surgery	2.			Feet		
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	3.			Hands		

Have you ever received a massage before? _____ When was you last session? _____

How did you know about me? _____

PLEASE INITIAL AGREEING TO THE FOLLOWING:

- I am responsible for any valuable items I bring into the massage studio with me.
- Draping will be used during all sessions.
- There will be NO breast massage performed on female clients.

Service Performed today: Swedish Massage Deep Tissue Hot Stone Reflexology

Massage therapy is given for stress reduction, relief from muscular tension and for enhancing circulation and energy flow. I understand that massage is not to be used in place of medical treatment. It is recommended that I see a physician for any medical problems I might have. I also certify that my medical history provided on this form is correct to the best of my knowledge.

Client signature _____

Date _____

Parent or Guardian (if under 18) _____

Date _____

Therapist Signature _____

Date _____