3100 Weslayan St. Suite 377
Houston, TX 77027
281-500-6001

Date: _____

Massage Client Information Form

Name: _____ Date of birth: _____ Gender: Male [| Female [ ]

Address: _____ City/State/Zip: _____

Home Phone: _____ Work/Mobile Phone: _____

Occupation: _____ Employer _____

Emergency contact: _____ Contact number: _____

Email Address: _____

Massage pressure preference: (please check) Soft [| Medium [| Deep [ ]

How would you like to be contacted: (Please check) Email [| Text [| Phone [ ]

How did you hear about our studio? Who referred you to us? _____

Medical Information

Yes [| No [| Have you had a massage before? If yes, how recently and how frequently?

_____

Yes [| No [| Do you frequently suffer from stress?

Yes [| No [| Do you have diabetes?

Yes [| No [| Do you experience frequent headaches?

Yes [| No [| Are you pregnant?

Yes [| No [| Do you suffer from arthritis? Where? _____

Yes [| No [| Are you wearing contact lenses?

Yes [| No [| Do you have high blood pressure? If so, do you take medication? Yes [| No [ ]

Yes [| No [| Do you suffer from epilepsy or seizures?

Yes [| No [| Do you suffer from joint pain or swelling? Where? _____

Yes [| No [| Do you have varicose veins?

Yes [| No [| Do you have any contagious diseases?

Yes [| No [| Do you have osteoporosis?

Yes [| No [| Do you have any allergies?

Yes [| No [| Do you have any skin conditions?

Yes [| No [| Do you bruise easily?

Yes [| No [| Have you suffered any broken bones? Where? _____

Yes [| No [| Have you been in an accident or suffered any injuries in the past two years? Explain below:

_____

Yes [| No [| Have you ever had a spinal injury or metal pins inserted anywhere?

Yes [| No [| Do you have cardiac or circulatory problems?

Yes [| No [| Do you suffer from neck or back pain?

Yes [| No [| Do you have numbness or stabbing pains anywhere?

Yes [| No [| Are you sensitive to touch or pressure anywhere?

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Yes [| No [| Have you ever had surgery? Please explain:

Yes [| No [| Do you have or have you ever had cancer?
Yes [| No [| Do you have any other medical conditions or are you taking any medications I should know about?

Yes [| No [| Do you have any tension or soreness (including strains/sprains) in a specific area? Please specify:

Yes [| No [| Are there any parts of your body you do not want massaged?

Yes [| No [| Do you have any systemic diseases? Please Explain:

Yes [| No [| Do you have a thyroid condition or any other hormone imbalances?
