Masterful Touch Massage

Client history

Date:

The following information is necessary to evaluate and meet your individual needs for professional treatment.
All information is confidential .

PLEASE PRINT THE FOLLOWING:
NAME: _____

ADDRESS:_____**APT#**_____**ZIP**_____

HOME#_____**WORK#**_____**CELL#**_____

M___F___BIRTHDAY:___/___/_____AGE:UNDER 21__ 21-30__31-40__41-50__51-60__60+__

OCCUPATION :_____

REFERRED BY:_____

HAVE YOU EVER HAD MASSAGE BEFORE? Y__N__
TYPE OF MASSAGE EXPERIENCED? DEEP TISSUE__SWEDISH__SHIATSU__OTHER_____
DO YOU PREFER MASSAGE PRESSURE TO BE: LIGHT___MED___FIRM___

LIFESTYLE QUESTIONS:

HOW MUCH PLAIN WATER DO YOU DRINK A DAY?_____
HOW MANY ALCOHOLIC BEVERAGES DO YOU CONSUME WEEKLY?_____
HOW MANY CAFFEINE BEVERAGES DO YOU CONSUME DAILY?_____
DO YOU SMOKE? YES____ NO____ IF YES, HOW MUCH?_____
DO YOU EXERCISE REGULARLY? YES____ N0_____
HOW MANY HOURS DO YOU SLEEP PER NIGHT?_____
WHAT IS YOUR DAILY STRESS LEVEL?_____

MEDICAL HISTORY:

DO YOU HAVE A HISTORY OF THE FOLLOWING?

__ABDOMINAL PAIN	__BURSITIS	__HEADACHES/MIGRAINES
__ACCIDENT	__CANCER	__HEART CONDITIONS
__ALCOHOLISM	__COLITIS	__HIGH/LOW BP
__ALLERGIES	__DECREASED ROM	__HYPER/HYPOTHYROID
__ASTHMA	__DIABETES	__JOINT ACHE
__BREAST AUGMENTATION	__DISK PROBLEMS	__ LOW BACK PAIN
__BROKEN BONES	__EPILEPSY	__ LYME DISEASE
	__GOUT	__SPRAINS/STRAINS

OTHER CONDITIONS OR INFECTIONS? EG; HIV/AIDS, TUBERCULOSIS
(PLEASE SPECIFY)_____

PLEASE GIVE ANY FURTHER INFORMATION OF THE ABOVE_____
_____
_____

WHAT MEDICATIONS IF ANY, DO YOU TAKE REGULARLY?
_____

IF SO, FOR?_____