

Today's date: _____



Massage Information Form

Name: _____ Birth date: _____

Is this your first professional massage? _____

If no, how often do you get a massage? _____

What do you hope to accomplish from today's massage?

Are you aware of any tension spots in your body? _____ If yes, location(s)

On a pain scale of zero to 10, where would you rate your pain right now? _____

Describe any surgeries, hospitalizations, accidents or injuries you have had in the last two years:

What kind of care did you receive for your accidents or injuries?

Do you feel that you have recovered from these events? _____

Do you have any chronic or ongoing pain? _____ Please explain: _____

What makes the pain worse? _____

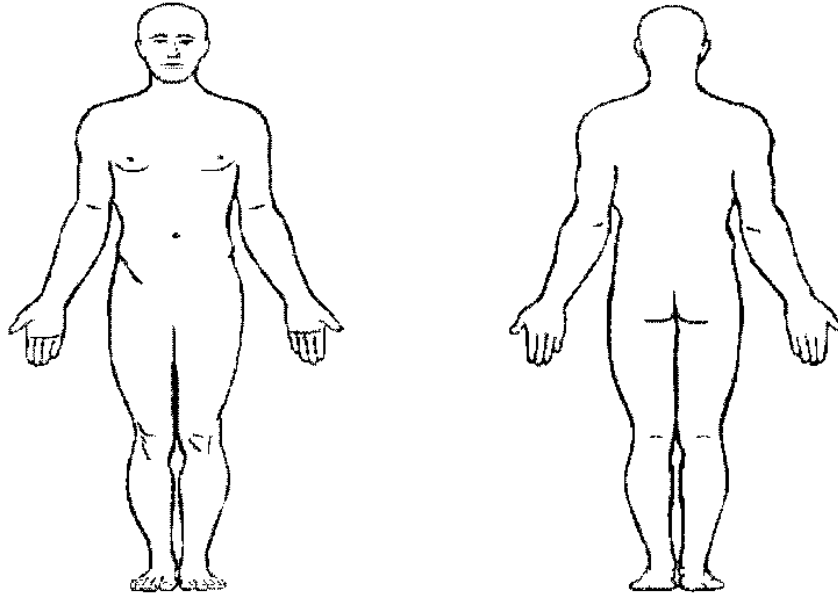
What do you do to make the pain better? _____

What is your favorite scent? _____

Do you have any sensitivity to heat or cold? _____ What is it? _____

Please indicate where you experience pain, stiffness or numbness on the drawing below

P = Pain, S = Stiffness, N = Numbness



You are here today because (please check one or more):

Gift (from whom _____)

Health reasons

Treat to self

Stress reduction

Regular Maintenance

Other (State _____)

Is there anything else that you want your therapist to know about your session today? _____

Signature: _____ Date: _____