

Clear Touch Massage

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

| | | | |
|-----------------|--------------|--|----------------|
| Name | Home Phone | Work Phone | Cell Phone |
| Address: Street | City | State | Zip Code |
| Date of Birth | Age | <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status |
| Email Address | Referred by: | | |

HAVE YOU EVER RECEIVED MASSAGE THERAPY? Yes No

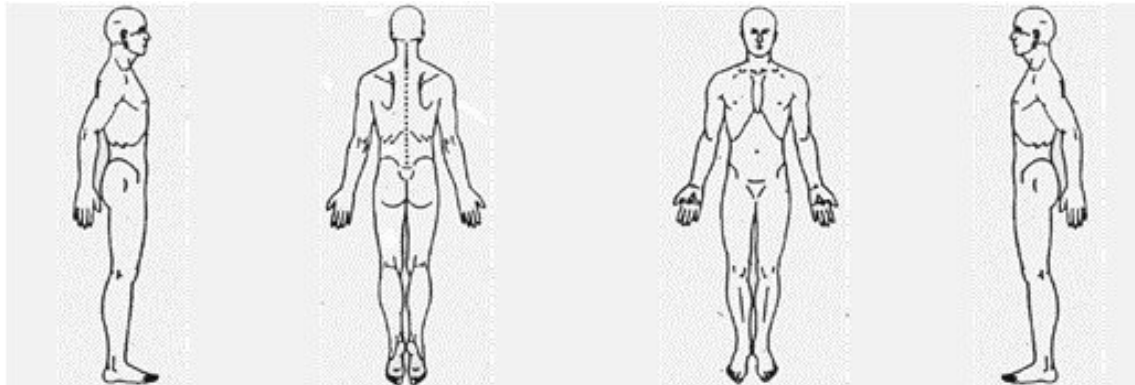
If yes, what type of massage have you experienced?

Deep Tissue Swedish Other(s) _____

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

- | | | | |
|--------------------------------------|---|---------------------------------------|--|
| <input type="checkbox"/> Sunburn | <input type="checkbox"/> Cuts, burns, bruises | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Irritated skin rash |
| <input type="checkbox"/> Severe pain | <input type="checkbox"/> Poison ivy | <input type="checkbox"/> Headache | <input type="checkbox"/> Cold or flu |

Shade in any area(s) where you are feeling discomfort



WHAT TYPE OF TOUCH DO YOU PREFER?

- Light/Meditative
- Heavy/Invigorating
- Deep/ Trigger Point

HOW MANY HOURS PER WEEK DO YOU PARTICIPATE IN SPORTS?

- Less than one hour
- One to two hours
- Three to four hours
- Five or more hours

HOW MUCH WATER DO YOU DRINK PER DAY?

- Less than two glasses
- Two to four glasses
- Five to seven glasses
- Eight or more glasses

WHAT ARE YOUR GOALS FOR MASSAGE?

- Relaxation
- Injury Rehabilitation
- High activity level, maintenance massage
- Other _____

WHAT IS YOUR MUSIC PREFERENCE?

You are welcome to look through my selection, or feel free to bring your own.

ARE THERE ANY OTHER HEALTH CONDITIONS I SHOULD BE AWARE OF? Yes No

If yes, please explain: _____

PLEASE READ AND INITIAL THE FOLLOWING, AND SIGN BELOW:

- I understand that this massage is not for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

Signature: _____ Date: _____