



Massage Profile & Release Form

All information will be kept confidential and used only by service professionals.

Name (Last, First, M.I.) _____ Date _____

Please list any pain, that you have, either reoccurring or recent. Where is it located?

Is discomfort/pain constant or does motion increase the pain? _____

What type of movements increases the pain? _____

When did the problems start and what activity caused it? _____

Are you under a physician's care: ____ For what condition: _____

Are you currently taking any medication(s): _____

Have you had a massage before: _____

Have you consumed caffeine or alcohol _____

If yes how much and how long ago? _____

Do you smoke ____ How much: _____

Occupation: _____

Goals for massage _____

In case of Emergency, Contact?

Name _____

Phone _____

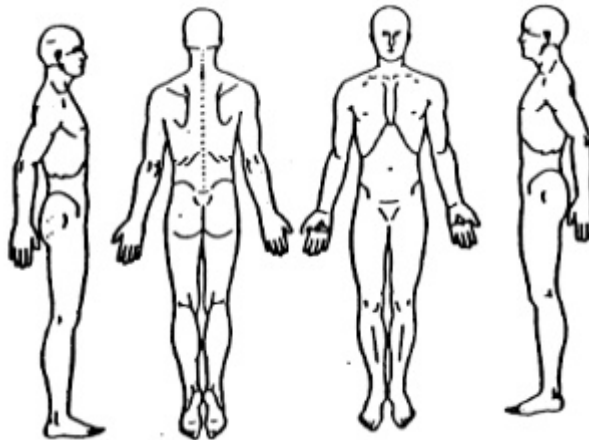
Do I have permission to contact your physician? _____

Name _____ Phone _____

If you have or had a history of any of the following, please check and give details below. Include any scars or operations.

- ___ Allergies: _____
- ___ Arthritis
- ___ Asthma
- ___ Blood clots
- ___ **Cancer (TURN OVER SHEET)**
- ___ Carpal Tunnel Syndrome
- ___ Contagious Diseases
- ___ Fibromyalgia
- ___ Fractures
- ___ Heart problems
- ___ High blood pressure
- ___ Lacerations
- ___ Lower back pain
- ___ Migraines
- ___ Pregnant Due date _____
- ___ Skin Diseases
- ___ Surgery _____ Date _____
- ___ TMJ Dysfunction
- ___ Upper back pain
- ___ Varicose Veins
- Other: _____

Please X areas of discomfort / pain. Then number next to the X on a scale of 1-10, 10 being the most painful.



I understand that the services offered are not a substitute for medical care and any information provided is for educational purposes only not diagnostically prescriptive in nature.

Client Signature _____ Date _____

Parental/Legal Guardian Signature for client under 18 years of age _____

Professional Signature _____ Date _____

