Advanced Therapy Solutions Your Therapy To Go

Specializing In On-Site Massage

Client Name Last First Would you like to be on our mailing list? _____

Address_____ Email Address_____
Street Zip code
Phone (____)_____ DOB_____ Occupation_____

Please take the time to answer these questions. They are for your protection and the therapist's. Your time and cooperation is appreciated.

Have you ever had a massage before? (Please circle) Yes or No
If so, how often do you receive a massage? _____
What qualities in your past massages did you like and or dislike? _____
_____
Do you have allergies of any form Yes or No
Please list_____
Are you currently taking any medication? Yes or No
Please list_____
Do you have sensitive skin? Yes or No
Do you have any skin problems? Yes or No
Please list_____
Are you currently under a doctor's care? Yes or No
Do you receive chiropractic adjustments? Yes or No
Do you have any circulatory problems? Yes or No
Do you bruise easily? Yes or No
Have you ever had any surgeries? Yes or No
Please list_____
Have you ever broken a bone? Yes or No
Have you ever had a serious accident? Yes or No
Please explain_____
Do you work out or play any sports? Yes or No
If so, how often? _____
Are you wearing contacts? Yes or No
How do you feel today? _____
What is your reason for receiving a massage today? _____

Please turn and continue on back of page.

Would you be interested in learning about vitamin and herbal supplements? _____
Where did you hear about us? _____

I understand the massage services are designed to be a health aid and are not to take the place of a doctor's care when it is indicated. Information exchanged during any massage is educational in nature and is intended to help you become more familiar and conscious of your own health status and is to be used at you own discretion. So with this information you give your consent to receive a massage.

Date_____ Your Signature_____

DIRECTIONS_____
_____
_____
_____

Therapist Comments

Date
Initials
Massage session length

_____
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