SOOTHING HANDS

CLIENT PROFILE

Name: _____ **Date** _____

Address: _____

Phone: _____ **DOB** (*mm/dd/yy*): _____ **Occupation:** _____

Please review the following list and check anything that might be relevant to you:

- ☐ Abdominal Pain
- ☐ Allergies (Oils, Nuts, Fragrances)
- ☐ Arthritis
- ☐ Auto-immune Condition
- ☐ Back Pain: ☐ Upper ☐Mid ☐ Lower
- ☐ Broken Bones
- ☐ Cancer
- ☐ Cardiac/Circulatory Condition
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Pain: _____
- ☐ Constipation/Diarrhea
- ☐ Contact Lenses
- ☐ Decreased Range of Motion
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Headache
- ☐ Herniated Disk
- ☐ High Blood Pressure
- ☐ Injury: _____
- ☐ Insomnia
- ☐ Muscle Strain/Sprain
- ☐ Numbness: _____
- ☐ Scoliosis
- ☐ Seizures
- ☐ Surgery: _____
- ☐ Skin Condition: _____
- ☐ TMJ
- ☐ Varicose Veins
- ☐ Whiplash
- ☐ Other: _____

☐ Are you seeing a health care professional? _____

☐ Are you currently taking any medications? (including aspirin, ibuprofen …)

_____

☐ List Areas to be Avoided during repeat Sessions: _____

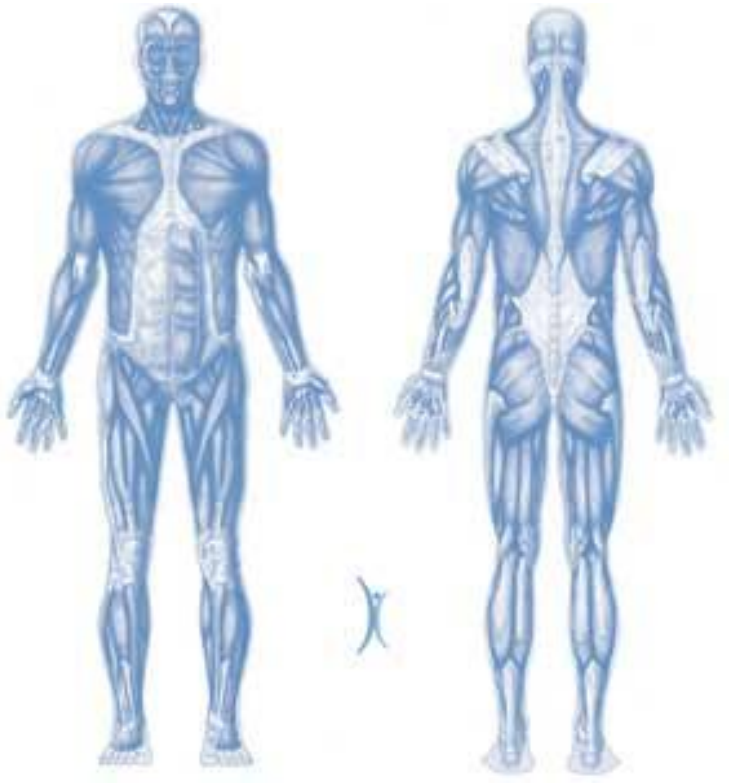
☐ Where do you usually hold tension? _____

☐ Preferred Level of Pressure: ☐ Light ☐ Medium ☐ Medium/Deep ☐ Deep

☐ How did you hear about us? _____

☐ Are you interested in promotional offers? ☐ Yes _____ ☐ No

(email)



On the diagrams, please indicate any areas in which you are currently feeling discomfort.
I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.

_____

Client's Signature

CLIENT FEEDBACK

We value your Feedback. Please take a moment to help us improve your next session

My favorite moment during the session was:

Something I wished had been different was:

Additional comments: