Everyday Grace
MASSAGE

Client Name:

Address:

Phone: Birthday:

Email:

Please list the reason you are seeking massage therapy: ______________________________
Have you received massage therapy before? Yes No
Are you under doctor's care? Yes No
List any health conditions you have had and/or are experiencing now: ______________________________

Emergency Contact:______________________________
Please circle any conditions you have or have had.
Blood Pressure: High Low
Diabetes Type One Two
Broken Bones: ______________________________
Sprains or Strains: ______________________________
Circulatory Disorders: ______________________________
Skin Disorders: ______________________________
Herniated Discs: ______________________________
Headaches: ______________________________
Carpal Tunnel: ______________________________
Surgeries: ______________________________
Other: ______________________________

All information here is correct and I have notified my massage therapist of all health concerns prior to our sessions. I am informed that I have the right to stop and give preferences to the work received at any time during the session and only move to my comfort level in each modality and exercise. I do not hold the massage therapist, property owners or the company Everyday Grace Massage liable in part or in whole in any case.

Client Signature: ______________________________Date: __________________

Postural Assessment: