Personal and Contact Information

Name:_____ Date:_____

Address:_____

Email: _____Phone: (Day)_____(Evening)_____

D.O.B: (M/D/Yr)_____ Age:_____ Ht: (ft/in) _____ Wt: (lbs)_____

Occupation:_____ Marital Status: (S M W)

Emergency Contact:(Name)_____ (Phone)_____

Primary/Referring Physician:_____

How did you learn about us?_____

Health & Medical History

What is your goal for today's session_____

_____

_____

Where do you typically feel stress on your body? (i.e. back/shoulders, etc)

_____

Do you feel any discomfort/pain? (Rate 1-10, 1-Mild to 10-Severe) Where?

_____

Please list all surgeries and injuries (treated or otherwise) with approximate dates:

_____

_____

Please list any known medical conditions/allergies:

_____

_____

_____

Please list any medication or OTC drugs or vitamins:

_____

_____

Do you drink? (Y/N) How often? _____ Do you smoke? (Y/N) How often?_____ Do you exercise? (Y/N) How often?_____

Family Medical History-Please list any known medical conditions:

Maternal _____

_____

Paternal_____

_____

Please check all current and previous conditions that apply to you:

Allergies _____	Depression _____	Insomnia _____	Sciatica_____
Anxiety _____	Diabetes_____	Infection _____	Soreness _____
Arthritis _____	Edema _____	Moles _____	Skin Conditions_____
Backpain_____	Fever _____	Muscular	Stress _____
Bruises _____	Fibromyalgia____	Problems_____	Tingling_____
Blood Clotting_____	Hives _____	Numbness _____	
Cancer_____	Headache_____	Open Sores_____	
Cold _____	Hypertension____	Pregnancy _____	

MS _____ (Do NOT use heating pad or heat in any way)

Other_____

Please check here if client has indicated a negative response to above list. _____

I, the client, understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

In consideration of using the Garage facility, treatments/programs, I agree, to the fullest extent permitted by law, to forever release, indemnify, defend and hold harmless the Garage, its subsidiaries and affiliates, their respective agents, officers, directors, owners, contractors and employees (collectively the "Released Parties") from any and all claims and causes of action which I (or the below-mentioned minor) might otherwise have or be entitled to assert as a result of or related to any physical injury or otherwise, including without limitation death or property damage or loss sustained in connection with my use (or the below mentioned minor's use) of the spa facilities or participation in any spa program or treatment, including, without limitation, claims and causes of action based on negligence, breach of warranty or breach of contract. I also agree to indemnify, defend, and hold harmless the Released Parties from any and all claims brought by third parties arising out of any (or the below-mentioned minor's) acts, errors, or omissions.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Treatment of Minor Under the Age of 17: By my signature below, I hereby authorize a Registered Licensed Massage Therapist to administer massage or bodywork therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____

S.O.A.P. Notes/Addendum

Client Initials or ID#: _____Client Sex: (M/F) Date of Massage:_____

D.O.B: (M/D/Yr)_____ Age:_____ Ht: (ft/in)_____ Wt: (lbs)_____

Blood Pressure: (Pre Massage)_____(Post Massage)_____

Client goals: (List 1 to 3)

_____

_____

_____

Subjective Findings (S):

_____

_____

_____

_____

_____

Objective Findings (O):

_____

_____

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_____

Action (A):

_____

_____

_____

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_____

_____

_____

Plan of Action (P):

_____

_____

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_____