Island Acupuncture
& Massage Therapy

Confidential Information – Massage

Last Name _____ First Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Address _____
(street) (city) (state) (zip)

Date of Birth _____ Occupation _____

Marital Status _____ Age _____ Sex: ☐ Male ☐ Female

Please list any allergies _____

Who can we thank for referring you? _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY? ☐ NO ☐ YES
If yes, what type of massage have you experienced? ☐ Deep Tissue ☐ Swedish ☐ Other _____

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

☐ sunburn ☐ severe pain ☐ poison ivy ☐ cuts, burns, bruises
☐ inflammation ☐ headache ☐ cold or flu ☐ irritated skin rash

WHAT TYPE OF TOUCH DO YOU PREFER?

☐ light/meditative ☐ heavy/invigorating ☐ deep/trigger point

HOW MANY HOURS PER WEEK DO YOU PARTICIPATE IN ACTIVITIES/SPORTS?

☐ less than 1 hour ☐ 1-2 hours ☐ 2-4 hours ☐ more than 4 hours

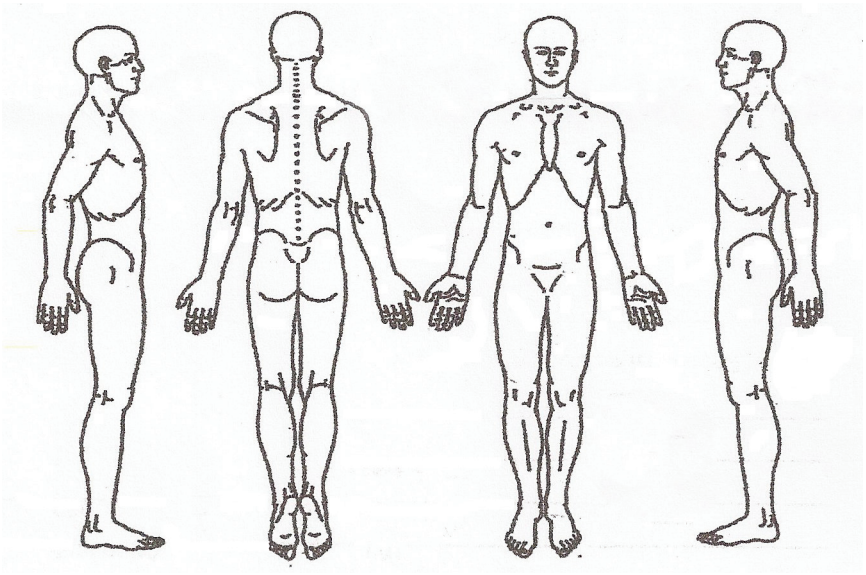
HOW MUCH WATER DO YOU DRINK PER DAY?

☐ less than 2 glasses ☐ 2-4 glasses ☐ 5-7 glasses ☐ 8 or more glasses

WHAT ARE YOUR GOALS FOR MASSAGE?

☐ relaxation ☐ injury rehabilitation ☐ high activity level, maintenance massage
☐ other _____

Shade in any area(s) where you are feeling discomfort.



HOW MANY HOURS OF SLEEP DO YOU GET PER NIGHT? _____

PLEASE LIST ANY OTHER HEALTH CONCERNS I SHOULD BE AWARE OF:

_____

_____

_____

_____

PLEASE READ AND INITIAL THE FOLLOWING, THEN SIGN BELOW:

_____ I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
_____ I am responsible for paying for any appointment cancellation of less than 24 hours.

Signature _____ Date _____

Tips are appreciated, but are not included in the price of your massage.