YOMASSAGE

THIS IS YOUR TIME OF LUXURY AND SELF CARE.

CHECK THE AREAS THAT NEED EXTRA ATTENTION

- ☐ Head
- ☐ Neck
- ☐ Shoulders
- ☐ Upper Back
- ☐ Lower back
- ☐ Hands
- ☐ Feet
- ☐ Calves

Name: _____

DOB: _____

Email: _____

Phone: _____

Emergency Contact Name and Number:

_____

What pressure do you prefer?

☐ Light ☐ Medium

Are there any areas you don't want massaged?

☐ Yes ☐ No

If yes: _____

By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. If client is under 18, parent must fill out form and sign below.

Client signature: _____

Date: _____

Parent signature: _____

Please indicate any condition that you have had or currently have:

- ☐ Headaches/ Migraines/ TMJ Problems
- ☐ Currently ill/ Infection
- ☐ Varicose Veins/ Blood Clots/ Bruise Easily
- ☐ Allergies/ Sensitivity
- ☐ Currently Pregnant
- ☐ Arthritis/ Tendonitis
- ☐ Epilepsy/ Seizures
- ☐ Cancer /Tumors
- ☐ Neck/ Back Injuries
- ☐ Diabetes
- ☐ Abnormal Skin Condition
- ☐ Heart/ Circulation Problems Fibromyalgia
- ☐ Joint Replacement/ Surgery
- ☐ High/ Low Blood Pressure, Sprains, Strains
- ☐ Major Accident Recent Injuries
- ☐ Lack of Sensation/ Numbness
- ☐ Chronic Pain/ Orthopedic Issues

Explain any condition you have marked above:

_____

_____

_____

_____