YOMASSAGE

THIS IS YOUR TIME OF LUXURY AND SELF CARE.

CHECK THE AREAS THAT NEED EXTRA ATTENTION	
☐ Head☐ Neck☐ Shoulders☐ Upper Back	Lower backHandsFeetCalves
Name: DOB: Email: Phone: Emergency Contact Name and Number:	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:
What pressure do you prefer? Light	
Are there any areas you don't want massaged? Glutes Feet Hair Face Other: 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:	4
Parent signature:	