Personal Information

Name ______________________________ DOB

Full Address ______________________________

Phone (day) ____________ (evening) ____________ Primary Physician ____________

Email ______________________________

Occupation ____________________ Employer ____________________

Emergency Contact ____________________ Relationship ____________

How did you hear about us? ______________________________

Medical Information

Are you taking any prescriptions?

Yes No

If yes, please list name and use:

____

____

Are you currently pregnant?

Yes No

If yes, how far along? ____________

Any high risk factors? ____________

Do you suffer from chronic pain?

Yes No

If yes, please explain: ____________

What makes it better? ____________

____

What makes it worse? ____________

____

Have you had any orthopedic injuries?

Yes No

Please indicate any of the following that apply to you:

- Cancer
- Headaches/Migraines
- Arthritis
- Diabetes
- Joint Replacements
- High/Low Blood Pressure
- Neuropathy
- Fibromyalgia
- Stroke
- Heart Attack
- Kidney Disfunction
- Blood Clots
- Numbness
- Sprains or Strains

Explain any conditions you have marked:

____

____

____

____

____

Breathing Space Therapies, LLC
ph: 920-455-9684 email: wiltgen@me.com

Massage Information

Have you had a professional massage before? Yes No

What type of massage are you seeking?

Relaxation Therapeutic/Deep Tissue Other: ____________

What pressure do you prefer?

Light Medium Deep

Do you have any allergies or sensitivities? Yes No

Please explain: ____

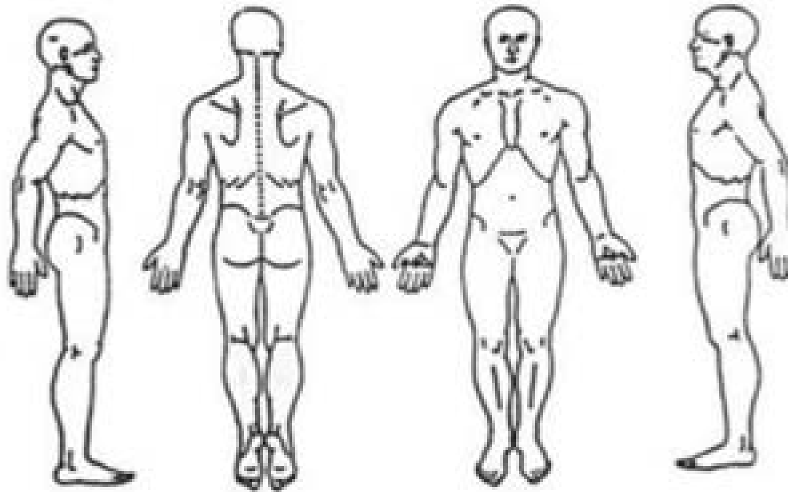
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? Yes No

Please explain: ____

What are your goals for this treatment session? ______________________________

____

Please circle (click) any areas of discomfort below:



Signatures Here

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.

____

Client Signature Date

____

Therapist Signature Date