



### Client Information

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What is your goal for this therapy session? \_\_\_\_\_

What type of pressure do you prefer? Light Medium Firm Deep

Indicate any areas of your body you prefer **not** to be massaged. Gluteal Area Pectoral Area Other \_\_\_\_\_

Have there been any changes in your health, medication, injury, surgeries, etc? (Y/N) \_\_\_\_\_

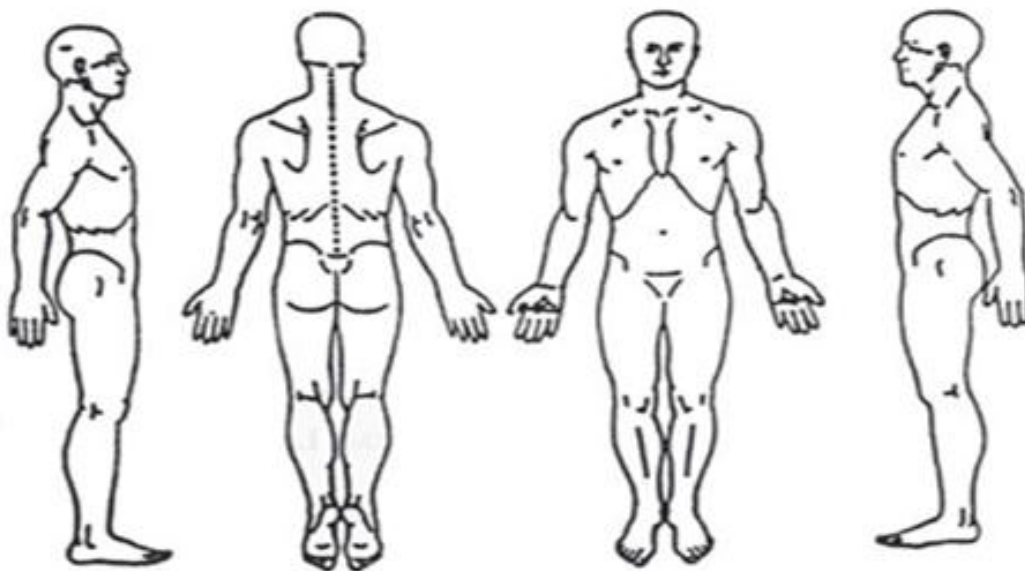
*Depict how you are feeling today by drawing a circle on the figures representing the size and shape of the following symptoms. Place the letter representing the symptoms in or near the circle:*

P = Pain, ache, or tenderness

S = Stiffness in the joint or muscle

N = Numbness, Tingling

W = Wound, bruise



*Rate how you are feeling today by drawing a circle around the number that best represents how you are doing today:*

|                       |   |   |   |   |   |   |   |   |   |   |    |                         |
|-----------------------|---|---|---|---|---|---|---|---|---|---|----|-------------------------|
| No pain               | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst pain imaginable   |
| Able to do everything | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Not able to do anything |

***I hereby give consent to receive therapeutic massage:***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_