



Client Information

Name

Address

City, State

Zip Code

Home Phone

Cell Phone

Email

Occupation

Date of Birth

Emergency Contact

Name

Phone

It is our priority to keep your contact information and medical history absolutely private and confidential. Soma Massage Therapy will not share any of this information, or any of the work that we do during your massage, with anyone, without either a subpoena or your written consent.

You may use the back of this form for additional information that you wish to provide. Please sign and date this form, stating that the information you have provided is correct to the best of your knowledge.

Signature

Date

Health History

Please list any medications you are currently taking:

Please list any allergies you have:

Please circle/highlight any conditions you currently have, or have had in the past:

- Arthritis
- Bruise easily
- Burstis Cancer
- Carpal Tunnel
- Chronic Fatigue Syndrome
- Cold hands or feet Diabetes
- Disk/Vertebrae problems
- Fibromyalgia
- Fungus
- Grinding teeth
- Headaches
- High blood pressure
- HIV
- Leg/foot cramps
- Loss of grip
- Loss of movement (where?)
- Migraines
- Numbness/Tingling (where?)
- Sciatica
- Skin condition
- Stiff neck
- Stroke
- Surgery
- Swollen ankles
- Thoracic Outlet Syndrome
- Ticklish feet
- TMJ
- Pain with coughing/sneezing (where?)
- Pain with lifting/bending (where?)
- Pain with movement (where?)
- Pregnant (due date)
- Whiplash