Soma Denton 531 N. Elm St. Denton, TX 76201 940-241-4490 soma@somadenton.com

soma
MASSAGE THERAPY™

Client Information

Name: first _____ last _____

Preferred/Nickname _____

Pronouns (she/her) (he/him) (they/them) other: _____

Email _____

Home Phone _____

Cell Phone _____

Address _____

City _____

State _____ Zip Code _____

Occupation _____

Date of Birth _____

Emergency Contact

Name _____

Phone _____

How did you hear about us?

Google | Facebook | Yelp | Newspaper
Other (please specify) _____

I was referred by a friend _____

It is one of our highest priorities to keep your contact information and medical history absolutely private and confidential. We 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 without your written consent.

Therefore, it is important that you are as detailed as possible so that we know what contraindications and accommodations need to be made in order to provide a safe and comfortable massage.

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.

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	Fibromyalgia	Skin condition
Bruise easily	Fungus	Stiff neck
Burstis	Grinding teeth	Stroke
Cancer	Headaches	Swollen ankles
Carpal Tunnel	High blood pressure	Thoracic Outlet Syndrome
Chronic Fatigue Syndrome	Leg/foot cramps	Ticklish feet
Cold hands or feet	Loss of grip	TMJ
Diabetes	Migraines	Whiplash
Disk/Vertebrae problems	Sciatica	

Loss of movement | where? _____

Numbness/Tingling | where? _____

Pain with coughing/sneezing | where? _____

Pain with lifting/bending | where? _____

Pain with movement | where? _____

Pregnant | due date _____

Surgery areas and dates _____

Signature _____ Date _____