Soule Wellness LLC Massage Therapy

Name: _____ Home Phone: _____
Street Address: _____ Work Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Date of Birth: _____ Occupation: _____
Emergency contact name: _____ Phone: _____

Have you had previous massage therapy/bodywork? _____ Date of last treatment: _____
How did you find out about this massage practice? _____
Why are you seeking massage therapy services today? _____

Please list any medication(s) taken and reason for taking it:

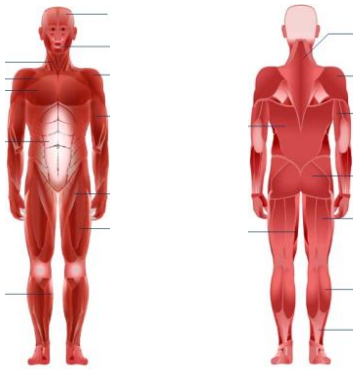
Medication	Reason for taking it
_____	_____
_____	_____
_____	_____
_____	_____

Do you have/had any of the following? Please circle.

Arthritis	Epilepsy/Seizures	High/low blood pressure	Spinal/back injury
Asthma/Respiratory issues	Fibromyalgia	Immuno-compromised disease	Varicose veins
Broken bones	Headaches/Migraines	Knee/Hip/Shoulder Surgery/Replacement	
Cancer	Heart disease	Lyme disease	
Diabetes	Hemophilia/Bruising tendency	Multiple Sclerosis	
Dizziness/Vertigo	Hernia	Pins/Pacemaker/Stents	

For women, are you currently pregnant? _____
Do you have skin sensitivities? Please describe: _____
Do you have any sensitivities to scents? Please describe: _____
Are you currently experiencing any infections, outbreaks, or skin irritations? Please describe:
_____
What type of regular exercise program are you involved in? _____ How often? _____

Please mark on the diagrams below any areas of discomfort:



I understand the following:

- I have disclosed all medical information that could contradict massage; and
- payment in the form of cash, check, or credit card is due at the time of the appointment.

Signed: _____ Date: _____