Krystal Massage

Name: ______________________ Email: ______________________________

Address: ____

Phone number ________________ Can I text you for appt. reminders? __________

D.O.B ______________________ Occupation: ___________________________

Emergency contact: ________________ Phone: ____________________________

How did you hear about me: ____

Have you ever had a professional massage before? ☐ Yes ☐ No

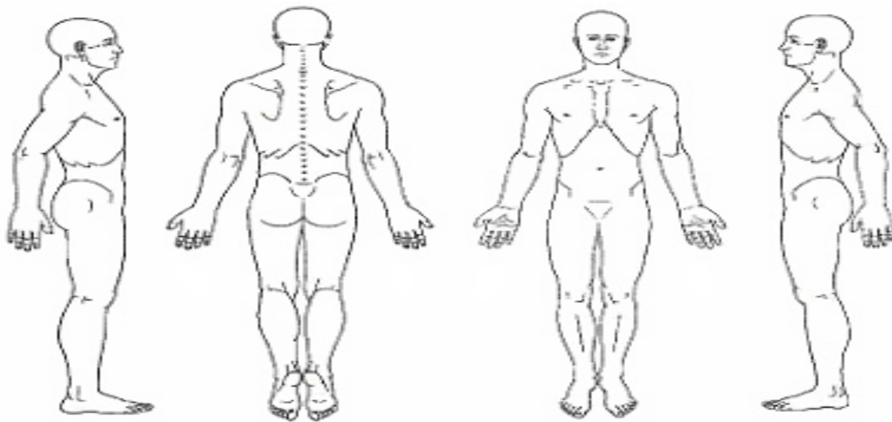
Do you have any difficulty lying on your side, back or stomach? ______________

Do you have any allergies or skin sensitivities to oils, lotions, or ointments? __________

Do you perform a repetitive movement at work, sports, or hobby? ______________

Is there a particular area where you are experiencing tension, stiffness, pain or other discomfort? ____

Do you have any specific goals for your massage session for today? ______________



Circle the areas that are currently bothering you, or areas you want focused on.

Mark an X on areas you do not want massaged. Ex. feet are ticklish.

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What activities cause these problem areas to increase in pain? ______________________

Are you taking any medications that could affect you during the massage ie: blood thinners. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

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☐ Skin Condition	☐ Easy Bruising	☐ Epilepsy
☐ Headaches,Migraines	☐ Recent Surgery	☐ Cancer
☐ Diabetes	☐ Current Fever	☐ Decreased Sensation
☐ Open wound/Sores	☐ Circulatory Disorder	☐ Back/Neck Problems
☐ TMJ	☐ Blood Clots	☐ Fibromyalgia
☐ Sprains/Strains	☐ Arthritis or Tendonitis	☐ Pregnant
☐ Recent Fracture	☐ Osteoporosis	☐ Tennis Elbow
☐ Recent Accident, Injury	☐ High or Low Blood Pressure	☐ Carpal Tunnel Syndrome

Please indicate areas that you have had or currently have

Draping will be used during the session-only the area being worked on will be uncovered. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client ____ Date______________