SERENITY MASSAGE WNY

Registration Form

Name:	Date of Birth:	Phone:	Email:
Street:	City:	State:	Zip:
Male ☐ Female ☐	Emergency Contact Name:		Phone:
How did you hear about me?			

Have you ever received massage therapy?
No ☐ Yes ☐
If yes, what type of massage? _____

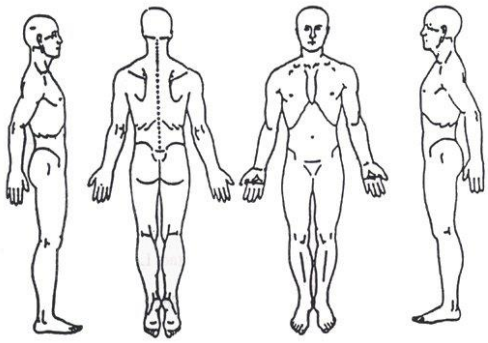
Do you have any of the following today?
- ☐ Sunburn
- ☐ Inflammation
- ☐ Severe Pain
- ☐ Headache
- ☐ Cuts/burns/bruises
- ☐ Irritated skin rash
- ☐ Poison Ivy
- ☐ Cold or Flu

What type of touch do you prefer?
- ☐ Light Meditative
- ☐ Heavy Invigorating
- ☐ Deep Trigger Point

How many hours per week do you participate in exercise, activities or sports?
- ☐ Less than one hour
- ☐ One to two hours
- ☐ Three to four hours
- ☐ Five or more hours

How much water do you drink per day?
- ☐ Two to four glasses
- ☐ Five to seven glasses
- ☐ Eight or more glasses

Shade in any area(s) where you are feeling discomfort:



How many hours of sleep per night? _____

What are the goals for massage?
- ☐ Relaxation
- ☐ Injury Rehabilitation
- ☐ High Activity level, maintenance massage

Other:_____

Are there any other health conditions I should be aware of?
No ☐ Yes ☐ *Please explain:*_____

Have you had surgeries/fractures: ***(list condition, dates and name of hospital where treated)***

_____

_____

Past medical history / Family Medical history: *(Mark "S" for self and "F" for family)*

- ☐ Hypertension
- ☐ Heart Disease
- ☐ Asthma
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Hypo/Hyperglycemia
- ☐ Nephritis
- ☐ Allergies
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Malaria
- ☐ Typhoid
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Jaundice
- ☐ Tonsillitis
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Mental Illness
- ☐ Colitis
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Boils
- ☐ Abscesses
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Herpes
- ☐ Cancer/Tumors
- ☐ Scoliosis
- ☐ Osteoarthritis

Other Symptoms: *(Please mark any that apply)*

- ☐ Headaches
- ☐ Dizziness
- ☐ Weakness
- ☐ Fatigue
- ☐ Labored Breathing
- ☐ Indigestion
- ☐ Heartburn
- ☐ Frequency of urination
- ☐ Night Voiding
- ☐ Throat Lump
- ☐ Numbness
- ☐ Fainting
- ☐ Swelling-Joints
- ☐ Gas
- ☐ Constipation
- ☐ Insomnia
- ☐ Poor Appetite
- ☐ Poor Memory
- ☐ Hot Flashes
- ☐ Excess Sweating
- ☐ Clammy Hands
- ☐ Palpitation
- ☐ Dry Skin
- ☐ Inner Tension

Other:

_____

_____

Please Read and Initial the following and sign below:
- ☐ I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- ☐ I am responsible for paying for any appointment cancellation of less than 24 hours.

Signature:_____ Date:_____