Massage Therapy
CONSULTATION FORM

Sweet Tea
Massage & Esthetics

PERSONAL INFORMATION

Name: _____ Date _____

Date of Birth_____ Age: _____ ☐ Female ☐ Male ☐ NB

Address _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

How did you hear about us?

MEDICAL HISTORY

Please check any conditions below that applies to you:

- ☐ Arthritis / joint disorder
- ☐ Artificial joint
- ☐ Atherosclerosis
- ☐ Blood disorder
- ☐ Back/neck problems
- ☐ Cancer
- ☐ Carpal tunnel syndrome
- ☐ Circulatory disorder
- ☐ Contagious skin condition
- ☐ Decreased sensation
- ☐ Deep vein thrombosis/blood clots
- ☐ Diabetes
- ☐ Easy bruising
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Fibromyalgia
- ☐ Headaches/migraines
- ☐ Heart condition
- ☐ High/low blood pressure
- ☐ Immune disorders
- ☐ Keloid scarring
- ☐ Open sores or wounds
- ☐ Osteoporosis
- ☐ Phlebitis, blood clots
- ☐ Pregnant
- ☐ Recent accident or injury
- ☐ Recent fracture
- ☐ Seborrhea
- ☐ Seizure disorder
- ☐ Skin disease/lesions
- ☐ Sprains/strains
- ☐ Swollen glands
- ☐ Tennis elbow
- ☐ TMJ
- ☐ Varicose veins

Please explain any condition that you have marked above: _____

_____

Any other condition? ☐ No ☐ Yes: _____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain: _____