



Jae Alberi, LMT  
Lic. #19114

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Referred By: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Birthdate (Month/Day/Year) \_\_\_\_\_ Occupation: \_\_\_\_\_

**MASSAGE HISTORY/TREATMENT INFORMATION**

Have you ever received a professional massage? \_\_\_\_\_ If yes, how often? \_\_\_\_\_

What results do you want from your massage sessions? \_\_\_\_\_

Please list daily activities (exercise/work/stressors) \_\_\_\_\_

Please list any preferences to scents/essential oils \_\_\_\_\_ Music Requests? \_\_\_\_\_

Are you currently seeing a medical practitioner? Please explain if yes. \_\_\_\_\_ Yes \_\_\_\_\_ No

List current medications, including aspirin, cortisone shots, etc. \_\_\_\_\_

**HEALTH HISTORY (Include year and treatment received)**

Surgeries: \_\_\_\_\_

Accidents/Injuries: \_\_\_\_\_

Please check any of these conditions that you have now, or that are relevant from the past

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> Cancer/Tumor          | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Numbness/<br>Tingling                          | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Contagious<br>Disease | <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Osteoporosis                                   | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sciatica                                       | <input type="checkbox"/> Varicose Veins  |
| <input type="checkbox"/> Blood Pressure<br>High/Low | <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> IBS           | <input type="checkbox"/> Skin Conditions<br>(Psoriasis, Fungus,<br>etc) | <input type="checkbox"/> Victim of Abuse |
|   | <input type="checkbox"/> TMJD                  |  |   | <input type="checkbox"/> OTHER:          |

Please elaborate on any conditions marked above:

It is my choice to receive massage therapy. I understand that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

(Initial Boxes)

I understand the cancellation policy and agree to the terms regarding late arrivals, and requirement of a 24-hour notice in order to avoid payment. I can view this on the website and/or request a hard copy.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_