Stacy Holmes, LMT www.strengthrestorative.com (517) 897-6382

Name: _____(please print clearly) Date of Birth: _____ Email: _____

Address: _____

Phone: _____ Cell / Work Emergency Contact: _____ Phone: _____

How did you hear about Strength Restorative Massage? _____

MilitaryService/Veteran Branch: _____ **Thankyouforyourservice!**

What areas of your body are causing discomfort?

_____

_____

Please List: Any diagnosed medical conditions? Medications? Surgeries? Accidents/traumas? What and when?

_____

_____

Allergies, Pregnancy, Rashes, Varicose veins, Etc...

_____

_____

Have you ever received Massage/bodywork before? Yes ☐ No ☐ Was there anything you liked or didn't like

_____

Please list any areas of your body you would prefer not be touched: _____

Occupation: _____ Physical activities: _____

I understand that the massage therapy that I will receive in no way constitutes medical treatment or diagnosis, and is performed with the therapeutic intent of relief from muscular tension, stress reduction, and improving lymphatic and blood circulation. I am responsible for consulting with my physician for any physical ailment that I may have.

I will communicate if any discomfort, pain, or other unusual symptoms are experienced during this or any future massages.

I understand that I will be denied massage if I currently have a fever, contagious or infectious disease, or am under the influence of drugs and/or alcohol.

Signature _____ Date: _____