**Remedial Zone**

**Client’s Form**

Client’s Name: Today’s Date:

Mobile: Time:

Email:

Age Range: (Please highlight)

Under 18 20s 30s 40s 50s 60s 70+

Any current injuries: (Please highlight) YES NO MAYBE

Tell us about your injury?

Please indicate that you are giving the massage therapist a permission to treat you today?

**YES NO**

**Requested Type of massage: Light Medium Firm/Deep**

Relaxation Remedial/Sports Deep Tissue Swedish HotStone Aromatherapy Facial Therapy Others

**Office Use Only:**

Range of Motion (ROM)

Active Passive Resisted

Focus Areas:

Pain/Tension

**Special Tests:**

**Therapy Plan:**

**Massage Application:**

**Referral Plan:**

**Notes:**