SYNCHRONICITY MASSAGE
THERAPY

Confidential Client Profile

Name ____ Date of birth __________________

Email address ____

Street address ____

City, State, Zip ____

Cell phone _________________ Home phone _________________ Work phone __________________

Occupation ____

Referred by ____

Have you received massage before? _____ How frequently do you receive massage? _____________

What do you expect from this treatment? ____

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Any areas to focus on in particular? ____

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Have you had any bad falls, broken bones, or other major traumas? ____________________________

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Have you had any hospitalizations, surgeries, or major illnesses? ______________________________

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Do you exercise or have any physical activities outside of work? _______________________________

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