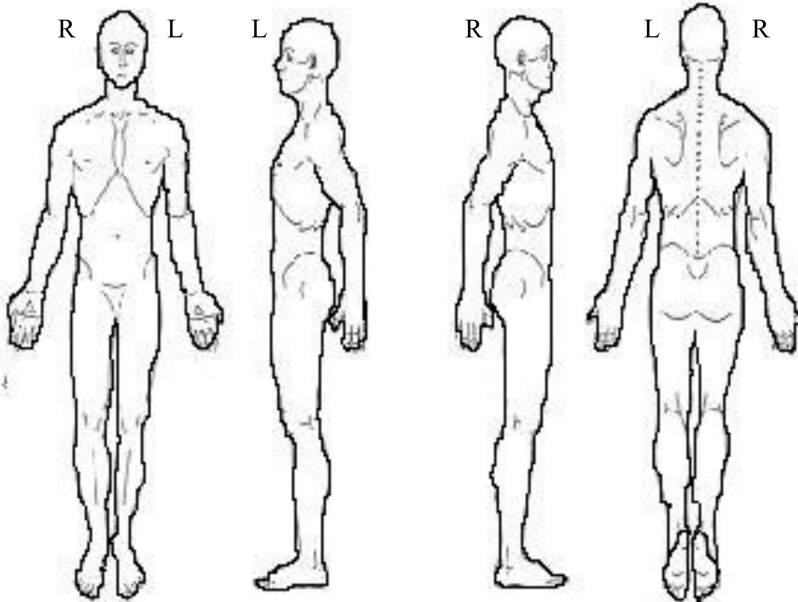
Touch of Serenity Massage Therapy

Client Name: ______________________

Last Name, First Name

Fill Out Only This Block



]

Please mark areas of pain or desired concentration for today's session.

List changes in your health for your Massage Therapist: ____________________

HOW DO YOU WANT TO FEEL AFTER THE MASSAGE?

➛ ____

Email address (only if changed): ______________________________

X **Signature** ____

Checkout

Date: ________ Time: __________

Therapist: ____________________

Session Length: _______________

Total Amount Paid: $___________

☐ check ☐ cash ☐ credit card

Discount: Type: ________ %$:____

Massage Fee: $_______________

Tip: $_______________

Products: $_______________

Referrals

Name: ________________________

Name: ________________________

Name: ________________________

Name: ________________________

Name: ________________________

SOAP NOTES (for Massage Therapist only)

Subjective (description of symptoms)

Objective (observations)

Assessment (record of changes in client)

Plan (list of recommendations)

- ☐ FBM
- ☐ Neck/Head/Jaw
- ☐ Shoulders R L
- ☐ Arm/Hand R L
- ☐ Mid Back
- ☐ Low Back/Psoas
- ☐ Hips/Glutes/ Piriformis
- ☐ Quads/Hamstrings
- ☐ Calves/Feet
- ☐ Pecs (explain)
- ☐ Abdomen (explain)

Pressure

- ☐ 1-3 ☐ 3-5
- ☐ 5-7 ☐ 8-10
- ☐ ________

- ☐ 1st Massage
- ☐ Intake Language
- ☐ Pain Language
- ☐ Incident Report
- ☐ Other

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Rebooked

Notes:

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Other:

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Rev. 4.7.22