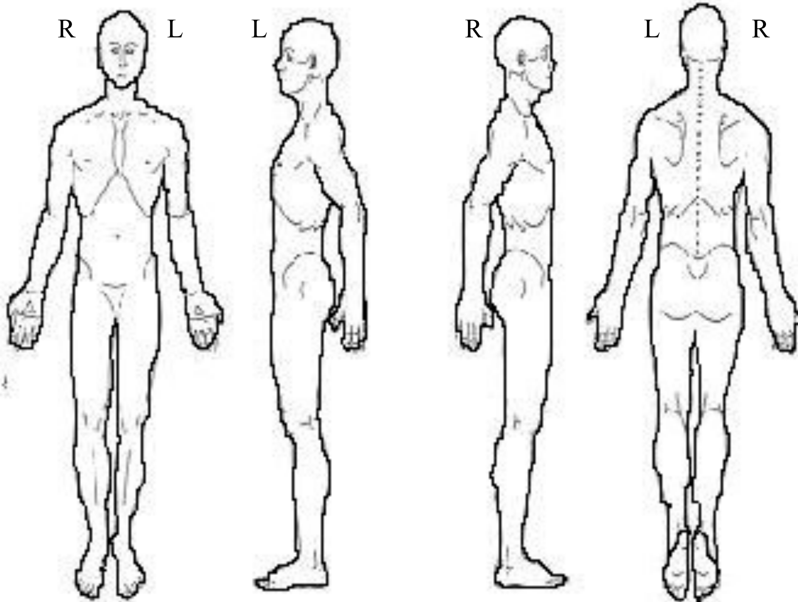
Touch of Serenity Massage Therapy

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: $______________

HEALTH QUESTIONS

- Have you had a Fever in the last 24 hours? Yes☐ No☐
- Cold/stomach/flu-like symptoms? Yes☐ No☐
- Contact with someone with a communicable disease in the last 10 days? Yes☐ No☐
- I will contact Touch of Serenity should I contract a communicable disease within 10 days. Yes☐ No☐

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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