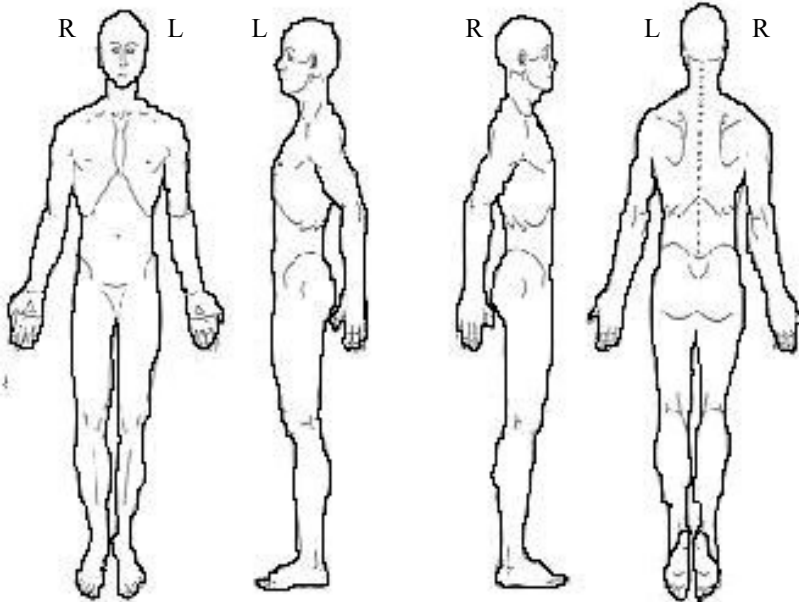


Fill Out This Block and Health Questions



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): _____

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

Rebooked

Notes:

Other: