



Chair Massage Registration

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, Zip: _____ Email Address: _____

Are you currently experiencing any of the following?

Pain Numbness Stiffness Stress Allergies

Current medications: _____

Recent injuries or health issues: _____

Recent accidents? _____

I understand that the massage being given is for the purpose of stress reduction, pain reduction, and the relief of muscle tension. I have provided all related medical information and will keep the massage therapist updated on any changes. I understand the massage therapist does not diagnose or treat disease or illness.

Client Signature: _____ Date: _____



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