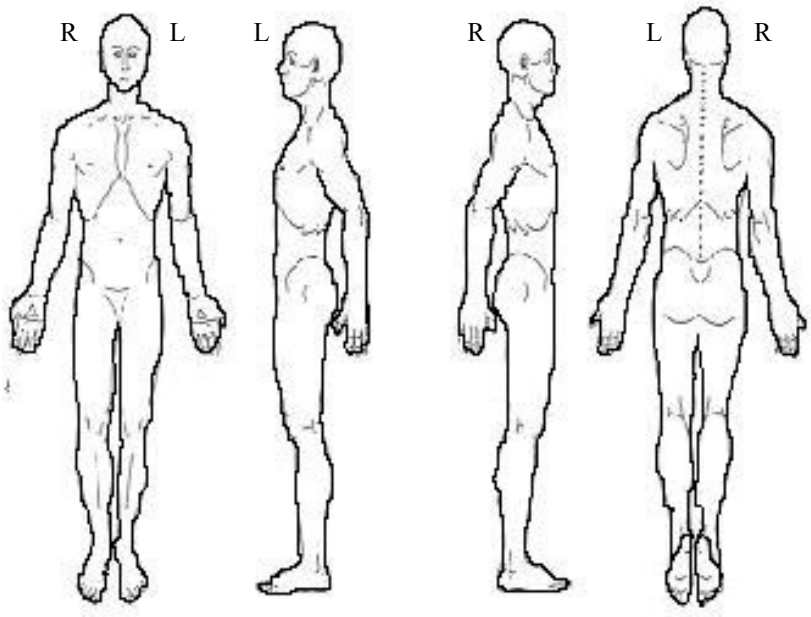
Touch of Serenity Massage Therapy

Client 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?

➔ _____

Make sure we have your **email address**: _____

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
- ☐ Shoulders 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:

_____

_____

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