PEAK PERFORMANCE
THERAPY
MOVE BETTER. FEEL BETTER. PERFORM BETTER.

Peak Performance Therapy

Sports Massage & Therapy Consultation Form

Personal Information

Full Name: _____

Date of Birth: _____ Phone: _____

Email Address: _____

Address: _____

Emergency Contact: _____ Relationship: _____

Medical History

■ Heart Condition ■ Diabetes ■ High Blood Pressure

■ Recent Surgery ■ Arthritis ■ Pregnancy

■ Allergies ■ Epilepsy ■ Skin Conditions

Please list any medications, injuries, or relevant medical conditions:

_____

_____
__

_____
_____
__

_____
_____
__

Treatment Information

Reason for Visit: _____

Areas of Pain/Tension: _____

Treatment Goals: _____

Lifestyle & Activity

Occupation: _____ Sport/Activity: _____ _____

Weekly Activity Level: ■ Low ■ Moderate ■ High

Consent & Agreement

I confirm that the information provided is accurate to the best of my knowledge. I understand that sports massage and therapy is not a substitute for medical treatment and I consent to treatment provided by Peak Performance Therapy.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____