Health Information-All information is kept confidential

Name-Mr.__Mrs.__Ms.__ _____

Address-Street or P.O. Box_____Apt. #_____City_____State_____Zip_____

Phone-Home( )_____Work( )_____Cell( )_____

Occupation_____Employer_____

Age_____ Date of Birth____/____/____ Sex- M F Height-_____ft._____in Weight-_____lbs

Have you had massage before? Yes_ No_ What is your preference of pressure? Light___Moderate___Deep____

Do you have any allergies or sensitivities to any oils, lotions, scents, etc.? Yes _No_ If yes, please list_____

Please list current medications and the purpose_____

_____

Please list any recent injuries and any surgeries, including dates:_____

_____

_____

Please list your areas of pain and discomfort_____

_____

Please circle any health conditions you have

Arthritis Carpal Tunnel High or Low Blood Pressure Stroke Tuberculosis Asthma

Cancer Edema Headaches Osteoporosis Varicose Veins Fibromyalgia

Cardiovascular/Heart Diabetes Back, Neck, or shoulder pain Sciatica Scoliosis Stress

Skin Problems HIV/AIDS Cold/Sinus Infection Phlebitis Thrombosis

Women only-Are you pregnant? No__Yes__How many months?___Your Due Date_____Any complications?_____

_____

Is there any additional information that would be helpful?_____

_____

How did you hear about my massage services?_____

I understand that massage is not a substitute for medical treatment and that no diagnosis or prescription is made or inferred. I agree to disclose any medical conditions, medications, or treatment that I may be receiving. I agree to update the massage therapist to <u>any</u> changes before the beginning of each following session.

Signature_____Date_____/_____/_____