Client Health Information

Name: _____ Referred by: _____

Address: _____ Phone – Day: _____

City/State/Zip: _____ Phone – Eve.: _____

Email address: _____

Date of Birth: _____ Occupation/Employer:_____

Are you under a healthcare provider's care? _____ For what? _____

Emergency contact: _____ Phone #: _____

Present medications you take: _____

Have you had a professional massage before? _____ Date of last massage _____

Your objective for this massage: _____

What do you do for exercise/relaxation? _____

Do you now have, or have previously had, any of the following? (check only those that apply)

___Recent injuries/illnesses
___Recent surgeries
___History or presence of cancer
___Undiagnosed new growths
___Heart or circulatory problems
___High blood pressure
___Varicose veins
___ Currently pregnant
___ Blood clotting disorder
___ Allergies to oils or perfumes
___ Thrombophlebitis
___ HIV positive
___ Diabetes
___ Kidney problems
___ Chronic neck/back/joint problems
___ Skin conditions/lesions

Any other information you would like me to know?_____
_____

To the best of my knowledge, this is an accurate representation of my medical and health history. I realize the treatment I will be receiving will be based on the information given. If my health or medical condition should change or if I take medications not listed on this form, I realize it is my responsibility to inform the massage therapist of any changes that have occurred.

I agree to be on time for my appointments and to accept financial responsibility for any appointments missed or cancelled without 24 hours notice..

Signature _____ Date _____