

name _____ date _____

day phone _____ evening phone _____

address _____

city _____ state _____ zip _____

email _____ date of birth (mm/dd/yy) _____

in case of emergency, contact _____ phone _____

the following questions are related to your massage experience:

what is your occupation (as related to standing / sitting / repetitive motions)? _____

where do you hold stress in your body (examples: shoulders / neck / stomach)? _____

list any tender to touch areas _____

describe your physical activity level _____

have you received professional massage in the past? ___ yes ___ no

if yes, what have you especially liked or disliked about massage? _____

what special goals do you have for your massage treatment? _____

in order for me to provide you with the safest and most effective massage possible, please answer the following:

identify any significant accidents, injuries or surgeries _____

are you currently receiving medical or other health care treatments? ___ yes ___ no

briefly identify _____

are you currently taking medication or supplements (prescription or over-the-counter) ? yes no

briefly identify _____

are you currently experiencing: infection inflammation contagious disease cold / flu fever

briefly identify _____

(women) are you pregnant or trying to become pregnant? yes no

are you currently (mark "C") or have you in the past (mark "P") experienced any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> allergies | <input type="checkbox"/> headaches | <input type="checkbox"/> psoriasis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> eczema | <input type="checkbox"/> ringworm |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> headaches | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> asthma | <input type="checkbox"/> heart ailments | <input type="checkbox"/> stiff joints |
| <input type="checkbox"/> back pain | <input type="checkbox"/> heart attack | <input type="checkbox"/> skin allergies |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> hemophilia | <input type="checkbox"/> strains / sprains |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> herpes | <input type="checkbox"/> stress, excessive |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> swollen feet / legs |
| <input type="checkbox"/> constipation | <input type="checkbox"/> insomnia | <input type="checkbox"/> tendonitis |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> tingling |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> migraines | <input type="checkbox"/> tumors |
| <input type="checkbox"/> digestive problems | <input type="checkbox"/> muscle spasms | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> disc problems | <input type="checkbox"/> numbness | <input type="checkbox"/> whiplash |
| <input type="checkbox"/> epilepsy / seizures | <input type="checkbox"/> phlebitis | <input type="checkbox"/> other: _____ |

please provide any other pertinent information _____

how did you hear about me? _____

please read and sign the following:

I acknowledge that the above information is complete and accurate to the best of my knowledge and will update my massage practitioner of new symptoms or conditions. I clearly understand that massage treatments are provided for therapeutic purposes only and are not intended to diagnose disease or injury. I agree to pay for scheduled massages unless cancelled or rescheduled within 24 hours of appointment time.

signature _____ date _____