PERSONAL DATA

Name ______________________________________ Date ________________________

Address ____________________________________ Phone- Day ___________________

City/ State/ ZIP _______________________________ Phone- Eve ___________________

Birth Date _________ E-Mail____________________ Occupation ___________________

Primary Health Care Provider ____________________ Phone ______________________

Emergency Contact ___________________________ Phone ______________________

Permission to consult with primary provider, if appropriate? Please initial if yes. Yes _____ No ***I understand that appointments cancelled with less than 24 hour notice will be billed at the full price.***

MASSAGE HISTORY/ TREATMENT INFORMATION

I ask these questions to better tailor my massage to your needs and to protect the health and well-being of my clients. Please answer them as best you are able.

What are your goals for health and how may I assist you in achieving your goals? _______________

____

Have you ever received a professional massage? Yes No

What results do you want from your massage today?

____

Are you currently experiencing any of the following? If yes, please explain.

Pain or Tenderness Yes No ___________ Stiffness Yes No _________________

Numbness or Tingling Yes No ________ Swelling Yes No _________________

What makes it better?_________________________Worse?______________________________

Please check the areas of your body that you give permission to receive massage.

Back Legs Buttocks Arms Abdomen Chest Neck Head Face Feet

Are you currently seeing a medical practitioner, including chiropractor, acupuncturist, DO, naturopath, etc., including psychotherapist or support group? If yes, please explain. Yes No -

____

List stress reduction and exercise activities, with frequency. ______________________________

List medication, including aspirin and ibuprofen, taken today. ______________________________

PREVIOUS HISTORY Include year and treatment received.

Surgeries ____

Accidents ____