PERSONAL CONTACT INFORMATION

Name: _____ Age: _____ Date of Birth: _____
Street Address:_____ Home phone: (_____)_____
City: _____ Cell phone: (_____)_____
State / Zip: _____ E-Mail Address: _____
Employer: _____ Work Phone: (_____)_____
Referred By: _____ Emergency Contact: _____
Personal Physician: _____ Emergency Contact #: (_____)_____

MASSAGE HISTORY / PREFERENCES

Have you received professional massage before? □ Yes □ No If yes, date of last massage: _____
What results do you want from your session(s)? _____
What areas would you like prioritized? _____

MEDICAL HISTORY

Major Illnesses, accidents and/or injuries: _____
_____
Please check any of the following that may apply: □ Wear contact lenses □ Communicable Illness
□ Pregnant or trying to become pregnant □ Infection or inflammation □ Allergies to oils or lotions

Check any of the following conditions that you are experiencing, or have experienced in the past:

	Current	Past		Current	Past
Heart problems	□	□	Arthritis/ Lumbago/ Gout	□	□
High Blood Pressure	□	□	Low Back Pain	□	□
Low Blood Pressure	□	□	Sciatica/ Numbness	□	□
Varicose Veins	□	□	Poor Circulation	□	□
Neck/ Spinal Injury	□	□	Migraines/ Headaches	□	□
Osteoporosis	□	□	Ovarian/ Menstrual Problems	□	□
Diabetes	□	□	Kidney/ Bladder Problems	□	□
Cancer	□	□	Bursitis/ Tendonitis	□	□
Respiratory Problems	□	□	Insomnia	□	□
Hayfever/ Allergies	□	□	Digestive Problems	□	□
Chronic Illness/ Pain	□	□	Skin Disorders	□	□
Fibromyalgia/ C.F.S.	□	□	Herpes/ Shingles	□	□
T.M.J./ Jaw Pain	□	□	Drug/ Alcohol Addiction	□	□
Lupus	□	□	Caffeine/ Nicotine Addiction	□	□

Please note any other medical condition that is affecting you: _____
Are you currently under the care of a physician for any of the above conditions? □ Yes □ No
Please list any medications you are taking: _____

PLEASE READ AND SIGN

I certify that the information provided above is true and accurate and that it is my choice to receive massage therapy. I agree to immediately notify my practitioner if any of the above listed conditions appear or change or if at any time the massage treatment causes any adverse physical reactions. I understand that massage practitioners do not diagnose Illness or disease or any physical or mental disorders. I also acknowledge that massage is not a substitute for medical treatment, examination or diagnosis and that it is recommended that I see my primary health care provider for those services. I recognize that I am responsible for keeping my scheduled appointments and I agree to pay for the treatments at the time of service unless otherwise arranged in advance. I also understand that if I fail to keep my scheduled appointment I will be responsible for the cost of the therapist's time.

_____ _____
Signature Date