PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name: _____ Date: _____

Address: _____ Phone (day): _____

City/State/Zip: _____ Phone (eve): _____

Email: _____ Date of birth: _____

Emergency contact: _____ Phone: _____

Doctor: _____ Phone: _____

Do we have permission to contact your doctor if necessary? Yes ____ No ____

MASSAGE HISTORY INFORMATION

Have you ever had a professional massage? No ____ Yes ____ Date of last massage _____

Is there anything you liked or disliked from previous massages?

Allergies:

What results would you like from your massage session?

CURRENT HEALTH TREATMENTS and PRACTICES

Are you currently seeing a doctor or other health care practitioner? Please explain if Yes:

Please list any medications you are currently taking and any you have taken within the last year (including chemotherapies, prescriptions, aspirin, herbs and supplements):

Drug	Reason for taking	Side effects

Do you attend support group meetings or see a counselor? Please explain if Yes:

Do you exercise or practice stress reduction activities? Include frequency.

PREVIOUS MEDICAL HISTORY

If you are or have been affected by any of the following, please comment in the space provided. Indicate whether it a past or present condition:

- Cardiovascular conditions (such as high blood pressure, angina, or stroke):

- Cancer, including the type of cancer and its location:

- Liver or kidney conditions:

- Respiratory or lung conditions (such as emphysema or asthma):

- Diabetes:

- Injuries (including accidents):

- Bone or joint conditions (such as arthritis, osteoporosis or bone metastases):

- Digestive conditions (such as IBS, constipation or diarrhea):

- Autoimmune conditions (such as lupus, CFS, or fibromyalgia):

- Other

TREATMENT HISTORY

Surgeries (please the list the type of surgery and the year):

Were lymph nodes removed?

Please list any other treatments that you have undergone, such as chemotherapy or radiotherapy, including the general dates:

Consent statement:

It is my choice to receive massage. I realize that the session is being given for the purposes of relaxation and comfort only. I agree to communicate with the therapist any time I feel that my well-being is being compromised.

I understand that massage therapists do not diagnose, prescribe for or treat medical conditions. I acknowledge that massage is not a substitute for medical examination or diagnosis. I have listed all medical conditions that I am aware of.

I am aware that is it in my best interest to notify my doctor that I am receiving comfort-oriented massage so that guidance can be provided.

SIGNATURE _____ DATE _____

Payment: I agree to pay posted prices and fees at the time of service. In the case of returned checks or other circumstances causing lack of payment, I will remit the full amount of service and all associated fees for collecting payment.

Cancellation Policy:
There is a 50% fee for cancellations (including reschedules) with less than 24 hours notice. You will not be assessed this fee if we can fill the appointment with another client. All cancellations must be done by phone; text messages and emails will not be accepted for the purpose of cancellations.

_____ Initials