CONTACT INFORMATION AND MEDICAL HISTORY

Name: _____ Date: _____

Phone: _____ Date of Birth: _____

Email: _____ Referred by: _____

Address: _____

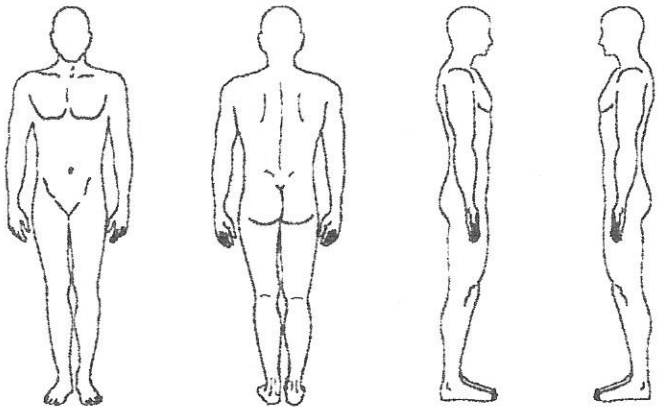
Emergency Contact: _____ Relationship: _____ Phone: _____

Have you ever received bodywork or energy work? ❑ Yes ❑ No If yes, when was your last? _____

What is the reason for your visit? _____

Are you experiencing any of the following? (Check yes or no. If applicable, please mark on the figures using the key below them.)

Yes	No	
❑	❑	Pain or tenderness
❑	❑	Numbness
❑	❑	Stiffness
❑	❑	Swelling
❑	❑	Cuts, burns, bruises
❑	❑	Headache
❑	❑	Cold, flu, other contagious illness
❑	❑	Cancer



KEY: O *pain* X *stiffness* ⚡ *numbness/tingling* # *bruises/open wounds*

List typical daily activities — work, exercise, stress reduction, and other. _____

_____

List current medications including pain relievers. _____

_____

List surgeries, accidents and major illnesses experienced currently or in the last 10 years. _____

_____

(Continue on the back of this form if you need more room for any answer.)

I understand that massage practitioners do not diagnose disease or provide medical treatment. I understand that massage is not a replacement for medical treatment, and I give my consent for massage. I understand I have the right to stop the massage at any time, and/or request different pressure.

Signature _____ Date _____