

CONTACT INFORMATION AND MEDICAL HISTORY

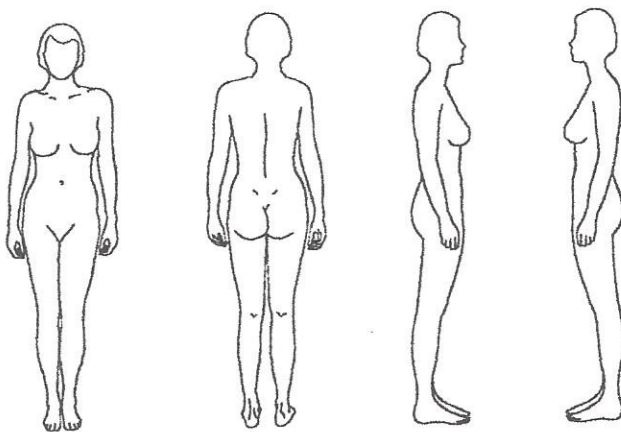
Name: _____ Date: _____
 Phone: _____ Date of Birth: _____
 Email: _____ Referred by: _____
 Address: _____
 Emergency Contact: _____ Relationship: _____ Phone: _____

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: ○ pain X stiffness ⚡ numbness/tingling # bruises/open wounds

Are you pregnant? Yes No
 If yes, when are you due? _____

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 _____

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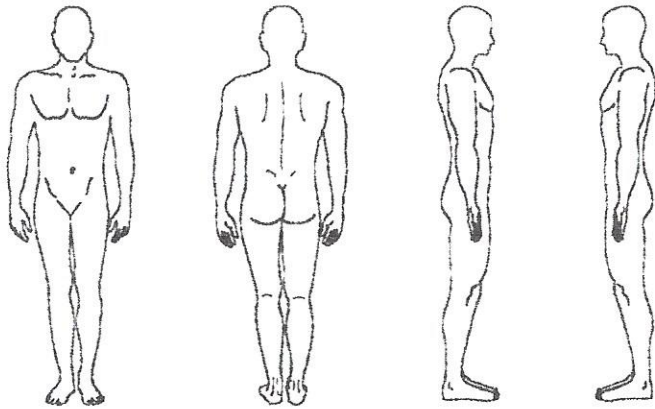
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