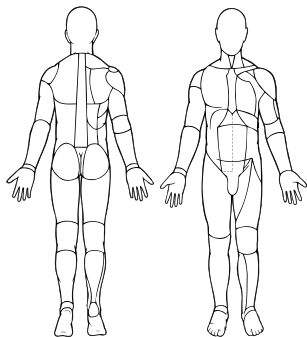


Client/Patient Health Information Form

Name (First) _____ (MI) _____ (Last) _____
 Address _____
 City _____ State _____ Zip _____
 Telephone (Home) _____ (Business) _____
 Date of Birth _____ Male ___ Female ___ Occupation _____
 What is your primary reason for massage? _____
 Who referred you? I would like to thank them. _____

Please check any condition(s) and/or symptom(s) that you have:



- | | | |
|---|--|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraine headache |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Muscular injuries |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Respiratory disorder |
| <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skeletal injuries |
| <input type="checkbox"/> Circulatory disorder | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Contagious disease | <input type="checkbox"/> Joint disorder | <input type="checkbox"/> Spinal disorder |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Other |

Please shade in the areas above that are causing you discomfort and /or pain.

Use this space to describe any of the above conditions and symptoms and list any additional conditions you may have _____

Physicians Name _____ Phone # _____
 Address (or office building) _____
 Date of last visit _____ Are you currently under a doctors care? Yes No
 If yes, please explain _____

Is there anything else that I should know about you, your health, or your body before administering massage therapy? Please describe _____

- I understand that the massage therapist does not diagnose. The massage therapist does not prescribe medical treatment or medications, nor do they perform spinal manipulations. Massage is not to be used as a substitute for medical examination or diagnosis and it is recommended that I see a physician for any ailments that I might have.
- I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.
- **I understand there is a 24 hour cancellation policy. If 24 hours notice is not given, I will be charged for the amount of the service.**

Date _____ Signature _____