Getting you back to a happy and peaceful state of mind.

Patient Name: _____ Patient DOB: _____
First Middle Last

Date of Initial Visit: _____

How would you rate your general health?

Excellent Good

Fair Poor

Have you had a professional massage before?

Yes *(Date of last treatment):* _____

No

List current medications and the conditions they treat: _____

_____

_____

_____

_____

Please tell us of any allergies or hypersensitivities:

_____

_____

_____

_____

_____

List any major accidents or surgeries and dates:

_____

_____

_____

_____

Reason for initial visit: _____

_____

_____

_____

_____

Halcyon Healing Massage
1867 Airport Way, Suite 155, Fairbanks, AK 99701
halcyonhealingmassage.com ~ halcyonhealingmt@gmail.com
Phone: (907) 385-8672 ~ Fax: (907) 519-0558

Head/Neck

- Headaches/Migraines
- Vertigo/dizziness
- Ringing in ears
- Hearing Loss
- Vision problems
- Vision Loss

Respiratory

- Asthma
- Shortness of breath
- Chronic cough
- Bronchitis
- Emphysema
- Sinusitis
- Frequent colds
- Smoker
- Family history of respiratory difficulties

Nervous System

- Sensory loss/change
- Numbness/tingling
- Sciatica
- Epilepsy
- Seizures
- Multiple Sclerosis

Musculoskeletal System

- Arthritis
- Osteoporosis
- Tendonitis
- Bursitis
- Jaw Pain (TMJ)
- Pins/Plates
- Wires/Artificial Joints

Reproductive

- Pregnant
- Given birth
- Gynecological problems

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Heart Attack
- Stroke
- Heart Disease
- Poor Circulation
- Phlebitis
- Varicose Veins
- Pacemaker
- Hemophilia
- Chronic Congestive Heart Failure
- Family History of Cardiovascular Problems

Skin and Infections

- Hepatitis
- HIV/AIDS
- Herpes
- Tuberculosis
- Lyme Disease
- Infectious Skin Conditions

Other Conditions

- Cancer
- Diabetes
- Fibromyalgia
- Depression
- Psychiatric Disorder
- Anxiety
- Digestive Issues
- Chronic Fatigue
- Unexplained Weight loss
- Other Conditions: _____

_____

_____

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It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage treatment. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature of Patient or Responsible Party: _____

Printed Name: _____

Relationship to Patient: _____ Date: _____