# PERSONAL HEALTH INFORMATION

**PERSONAL DATA .**

Name: _____ Date: _____ Referred by:_____

Address: _____ Phone: _____ Mobile: _____

City/State: _____ Zip:_____ Occupation/Employer: _____

Birthday: _____ Length of Session: _____

Email Address: _____

Emergency contact: _____ Phone: _____

**MASSAGE HISTORY/TREATMENT INFORMATION .**

Have you ever received a professional massage? ☐No ☐Yes Date of Last Massage: _____

Do you have any allergies to massage lotion/oil ingredients? ☐No ☐Yes

List stress reduction and exercise: _____

_____

List current medications, including aspirin, ibuprofen, herbs, supplements, etc. _____

_____

Please check the areas of your body that you give permission to receive massage:

☐back ☐legs ☐arms ☐neck ☐head ☐face ☐buttocks ☐feet ☐upper chest

**PREVIOUS HISTORY .** (Include year and treatment received)

Surgeries: _____

_____

Int _____ Date _____ Int _____ Date _____ Initial and date

Massage Type: ☐Swedish / relaxation ☐Firm ☐Deep Tissue Level 1-4

_____

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It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. Treatment benefit may include stress reduction, muscular tension, spasm or pain relief, as well as increased circulation or energy flow. I agree to communicate with my therapist any time I feel that my well-being is being compromised.

I acknowledge that massage is not a substitute for medical examinations or diagnosis and that it is recommended that I see a primary health care provider of that service.

I have stated all medical conditions and surgeries that I am aware and will update the therapist of any changes in my health status.

SIGNATURE: _____ DATE: _____

Int _____ Date _____ Int _____ Date _____Initial and date

Int _____ Date _____ Int _____ Date _____form for follow up

Int _____ Date _____ Int _____ Date _____ and visits.

Int _____ Date _____ Int _____ Date _____