TINA'S THERAPEUTIC TOUCH
Massage Studio Inc

INTAKE / HEALTH HISTORY FORM

NAME: _____ **DATE:** _____

BIRTHDAY MONTH & DAY: _____ **REFERRAL SOURCE:** _____

EMAIL: _____ **BEST CONTACT NUMBER:** _____

(Enter Y for YES Enter N for NO)

_____DIABETES		____HIGH/LOW BLOOD PRESSURE
_____STROKE	_____CANCER	_____ARTHRITIS
_____HEART ATTACH	_____HIV / AIDS	_____HERNATED DISCS
_____HEART DISEASE	_____ANY CONTAGIOUS DISEASES	_____EPILEPSY / SEIZURES
_____FIBROMYALGIA	_____SKIN RASH CONTAGIOUS	_____NECK PAIN / WHIPLASH
_____KIDNEY DISORDER	_____EASY BRUSING	_____HEADACHES
_____BLOOD CLOTS		_____LUPUS

OTHER: _____

HISTORY OF FRACTURES: _____ **SURGERIES:** _____ **WHEN WAS YOUR LAST MASSAGE?** _____

Client's Signature _____ Date: _____

Therapist's Signature: *Tina Marie Licensed Massage Therapist* Date: _____