

First Name _____

Date of birth _____

Last Name _____

Referred by _____

Email Address _____

Mobile Phone # _____

Home Phone # _____

Work Phone # _____

Street Address _____

City _____

State _____

Zip Code _____

Emergency contact name _____

Physician's name _____

Emergency contact relationship _____

Physician's phone # _____

Emergency phone # _____

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 & the conditions they are treating

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

Reason for initial visit

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 Family history of arthritis
- Osteoporosis Tendonitis
- Bursitis Jaw pain (TMJ)
- Pins / plates / wires / artificial joint

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 & INFECTIONS

- Hepatitis HIV / AIDS
- Herpes Tuberculosis
- Lyme disease Infectious skin conditions

OTHER CONDITIONS

- Cancer Diabetes
- Unexplained weight loss Digestive conditions
- Fibromyalgia Chronic fatigue syndrome
- Depression Anxiety
- Psychiatric disorder
- Other conditions _____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or 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.

_____ I consent to receive appointment updates and promotional messages from The Well Day Spa LLC. I understand I can opt out of promotions separately. Message & data rates may apply.

Signature: _____ Date: _____