



IN TOUCH
massage and wellness

PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name _____ Referred by _____
 Address _____ City/State/ Zip _____
 Home Phone _____ Work Phone _____ Can we give you an appt. reminder call? __Y__N
 e-mail address: _____ for birthday & holiday specials only.
 Birthdate _____ Age _____ M ___ F Marital Status _____ Occupation _____

MASSAGE HISTORY

Have you ever received a professional massage before __Y__N If yes, how long ago _____ frequency _____
 Type of massage your received: Deep Tissue __ Relaxation __ Other _____
 What results do you want from your massage sessions? _____
 Prioritize the areas of your body that you would prefer to be massaged _____
 Are you currently under the care of a medical practitioner? __Y__N Are you on medications? __Y__N
 If so, please explain briefly: _____
 Do you exercise regularly? _____

HEALTH HISTORY Please mark (X) for all problems or conditions that are effecting you at the current time

<input type="checkbox"/> Head	<input type="checkbox"/> Abdomen/Digestion	<input type="checkbox"/> Plantar fasciitis	<input type="checkbox"/> Arthritis/Bursitis
<input type="checkbox"/> Neck	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Lupus
<input type="checkbox"/> Shoulders	<input type="checkbox"/> Hips	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Chest	<input type="checkbox"/> Thighs	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Fatigue/Sleep Disorder
<input type="checkbox"/> Lower Back	<input type="checkbox"/> Knees	<input type="checkbox"/> Jaw pain/TMJ	<input type="checkbox"/> Constipation/IBS
<input type="checkbox"/> Middle Back	<input type="checkbox"/> Lower Legs	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Arms	<input type="checkbox"/> Ankles	<input type="checkbox"/> Heart Condition/Circulation	<input type="checkbox"/> Allergies
<input type="checkbox"/> Hands	<input type="checkbox"/> Feet	<input type="checkbox"/> Blood Clots/Varicose Veins	<input type="checkbox"/> Sinus/Breathing
<input type="checkbox"/> Warts	<input type="checkbox"/> Athletes Foot	<input type="checkbox"/> HIV/AIDS/Infectious Disease	<input type="checkbox"/> Stroke/Seizures

Other areas of problems: _____
 Any surgeries within the last 2 years? _____

CONSENT

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. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner anytime I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorders; nor perform spinal thrust or manipulations. I understand that massage is not a substitute for medical examinations or diagnosis, and that it is recommended that I see a Primary health care provider for that service.

I have disclosed all medical conditions that I am aware of at this time and I will update the therapists as necessary.

SIGNATURE _____ DATE _____