

Massage New Patient Information

Personal Information

First Name: _____ MI: _____ Last: _____

Address: _____

City _____ State _____ Zip _____
Phone Number: _____ Work/Cell Phone Number: _____

Date of Birth: _____ Occupation: _____

Email Address: _____ for News and Discounts

Emergency Contact: _____
Relationship _____ Phone Number _____

Have you ever had a professional massage before? YES NO If yes, how long ago? _____

Health Information

List Current Medications: _____

List Any Allergies: _____

Current or Past Health Conditions: _____

PLEASE CHECK ANY THAT MAY APPLY TO YOU

- | | | |
|--|--|---|
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> H/L Blood Pressure | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Circulation Disorders | <input type="checkbox"/> Contagious Diseases | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Cancer |

Please **CIRCLE** the areas of the body that need the most attention. Place an **X** over any area that you wish to have avoided.

Massage therapy, as provided in this office, is for the purpose of muscular re-education, relief of muscle tension, increased circulation and stress reduction. Massage therapists do not diagnose nor treat illnesses or disorders. They do not perform spinal manipulation, prescribe medications nor perform physical examinations. It is important that you indicate any current health problems and update us on any new problems as they arise. Failure to do so relieves us of any consequences that may result from such actions.

I read the above statements and by signing below am indicating that I understand and accept them.

Patient Signature

