

Confidential Health History

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Occupation: _____

Email: _____ Referred by: _____

In case of emergency, please contact:

Name: _____ Phone: _____

What is your primary objective for seeking bodywork? _____

Have you ever had a professional therapeutic massage? Yes No Date of last Tx _____

What is the main reason for your visit today? _____

Hours per day spent at desk or computer: _____

Do you suffer from any of the following:

Stress (Frequency _____)

Headaches (Frequency _____)

Neck pain (_____)

Shoulder pain (_____)

Back pain (_____)

Hip/Pelvic pain (_____)

Pain in the: Arm/Wrist/Hand Leg/Knee/Ankle/Foot

Sleep difficulty (_____)

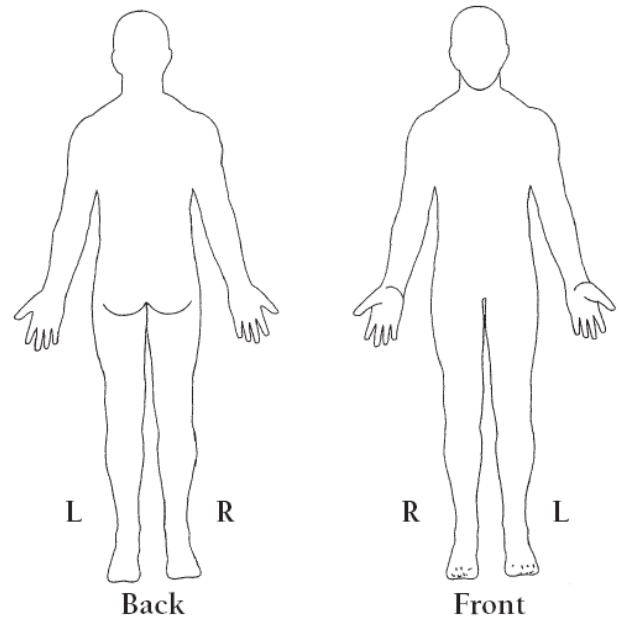
Swelling Infections or communicable diseases

Skin conditions or allergies (_____)

Diabetes Arthritis Asthma Cancer Osteoporosis

Currently pregnant. Expected delivery: _____

Other (_____)



Please mark areas of pain or injury on the diagram.
Cross out any areas you would like avoided.

Please list injuries and/or surgeries, and medications:

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the therapist of any changes in my status. I understand that in the bodywork session(s) my comfort level will always come first and that I, or the therapist, may request the treatment to stop or change for any reason. I agree to payment at the time of service by cash, credit card or check. A \$25 fee will apply to all returned NSF checks.

I am aware there is a 24 hour cancellation policy and I may be billed the fee for my reserved session time if I do not provide sufficient notice when canceling or changing my appointment.

Client Signature _____ Date _____