the gift of relaxation

MASSAGE THERAPY | AESTHETICS

personal information

last name | first | middle initial

address

city | state | zip | date of birth | age

email address

occupation | best number to reach you | reffered by

emergency contact name | relationship to you | emergency cocntact phone

current medical conditions

First Time Receiving A Massage? ☐ YES ☐ NO

Primary reason for your visit: ______

List any current medications/supplements: ______

Please list all recent or past injuries / medical conditions with approximate dates: ______

Please check all that apply, and explain in the space provided. ☐ Check here if NO to all

allergies	☐	______	high blood pressure	☐	______
arthritis	☐	______	neck / spine injury	☐	______
cancer	☐	______	phlebitis	☐	______
chronic back pain	☐	______	pregnancy	☐	______
diabetes / hypoglycemia	☐	______	skin disorders	☐	______
fever	☐	______	varicose veins	☐	______
frequent headaches	☐	______	other	☐	______
seizures	☐	______	other	☐	______
heart problems	☐	______	other	☐	______

Are you currently under the care of a health professional? ☐ YES ☐ NO

health care provider's name | health care provider's phone number

patient signature | date

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