

Mountainside Wellness Therapeutic Massage Information Form

Name _____

Birth
Date _____

Address _____

Telephone #

City _____ ST _____ Zip _____

Occupation _____

Business #

How did you learn about us? _____

What do you hope to accomplish from today's
massage? _____

Have you received a professional massage before? _____ If So, How Often? _____

Do you have a pressure preference, light/med/deep? _____

Women Only: Is there any chance you may be pregnant? _____

Please check off any of the following conditions or symptoms which apply to you now or in the past:

- | | | |
|--|--|---|
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Muscle Sprain / Strain |
| <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Back/Neck Pain | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stomach Ailments |

Do you suffer from chronic/persistent pain/discomfort? _____

Please list and explain other conditions/symptoms you are or have experienced: _____

Have you had any serious or chronic illness, operations, or traumatic accidents? _____

If yes, please explain: _____

Are you currently, or have you at any time within the last 12 months been under the care of a physician?
If so, for what condition? _____

Do you see a chiropractor? _____ If so, how often? _____

Are you on any medication? _____ If yes, which ones? _____

How many ounces of water do you drink per day? _____

-OVER-

I have completed this health form to the best of my knowledge. I understand that Massage Therapy services are a therapeutic health aid. They do not take the place of a physician's care when indicated. Any information exchanged during a Massage session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call ASAP to reschedule my appointment.

If I miss a scheduled appointment without giving 24 hour notice, I agree to pay any missed appointment charge applicable.

I am responsible to pay for any/all Massage fees.

Name (signature) _____ Date _____

Please Mark an X on the picture where you have pain, numbness or tingling.

