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:

____ High/Low Blood Pressure	____ Blood Clots	____ Muscle Sprain / Strain
____ Herniated Disc	____ Allergies	____ Heart Condition
____ Back/Neck Pain	____ Varicose Veins	____ Arthritis
____ Fibromyalgia	____ Bursitis	____ Headaches
____ Osteoporosis	____ Skin Conditions	____ Sciatica
____ Diabetes	____ Shoulder Pain	____ HIV/AIDS
____ Numbness/Tingling	____ Insomnia	____ 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.