

CONFIDENTIAL PERSONAL HEALTH INFORMATION

Name: _____ Date: _____
 Address: _____ Message Phone: _____

 City/State/Zip: _____ **Email for bi-weekly Massage Opening/**
Updates:
 Occupation: _____
 Birthday: _____ Emergency Contact & Number: _____

MESSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? Yes No If yes, frequency _____
 What do you like most about your massage sessions? _____

 What did you like least about massage treatments you received in the past? _____

 Prioritize the areas of the body that you would prefer to be massaged. _____

List current medications, including aspirin, ibuprofen, etc. _____

If you answer "yes" to any of the following questions, please explain as clearly as possible below:

Do you experience or have been diagnosed with: (check all that apply)

<input type="checkbox"/>	frequent headaches	<input type="checkbox"/>	bruise easily
<input type="checkbox"/>	diabetes	<input type="checkbox"/>	cardiac or pulmonary problems?
<input type="checkbox"/>	arthritis	<input type="checkbox"/>	numbness or stabbing pain. Location? _____
<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	wear contacts or dentures
<input type="checkbox"/>	epilepsy or seizures	<input type="checkbox"/>	digestive problems
<input type="checkbox"/>	contagious diseases	<input type="checkbox"/>	circulatory issues
<input type="checkbox"/>	osteoporosis or scoliosis	<input type="checkbox"/>	nervous system disorders
<input type="checkbox"/>	allergies	<input type="checkbox"/>	Any other issues the therapist may need to be aware of?

It is my choice to receive massage therapy. **I agree to communicate with my practitioner any time I feel like my well being is being compromised.** I understand the massage practitioner does not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged a \$40 fee for the time booked. In the case the patient misses more than three appointments in a 12 month period; the patient will no longer be a patient of A Better Way Massage, LLC

SIGNATURE: _____ DATE: _____ 3.09