MASSAGE ASSOCIATES

HEALTH SCREEN

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Please provide best contact number: cell / office / home _____

Email: _____ Referred by/How did you hear about us?_____

Occupation: _____ Have you ever had a professional massage: Yes _____ No _____

Reason for your visit (relaxation, pain relief, etc.); any specific areas of tension/concern? _____

_____

Emergency Contact: _____ Phone: _____

Medical Information

Please make us aware of any medical conditions you may have. Include any recent rashes, breaks, sprains, surgeries or illnesses.

Are you currently under medical care? _____ If yes, please provide brief reason. _____

Medical conditions: _____

Medications and their use: _____

_____

Is there any chance you are pregnant? Yes_____ No_____ Due date: _____

Do you have any allergies? Yes_____ No_____ Allergen(s): _____

PLEASE READ AND SIGN

I have read the preceding information and understand it is my responsibility to inform the therapist of any of my health changes and issues prior to each session. I understand that this work does not constitute medical treatment. Appointments cancelled with less than 24 hours notice will be charged the session fee. The therapist may refuse service at any time.

Signature: _____ Date: _____