

Name _____ Date of Birth _____

Phone(s) _____ E-mail _____

Address _____

Occupation _____

Emergency contact _____ Phone _____

Have you ever received massage therapy before? Yes No Frequency _____

Reason for today's visit _____

Desired results of today's session _____

This concern is Minor Problematic Major
 Recurring Getting worse Getting better

Have you had this concern before? Yes No Explain _____

Have you sought treatment for this before? Yes No Explain _____

Are any of your activities affected by this? _____

Current medications _____

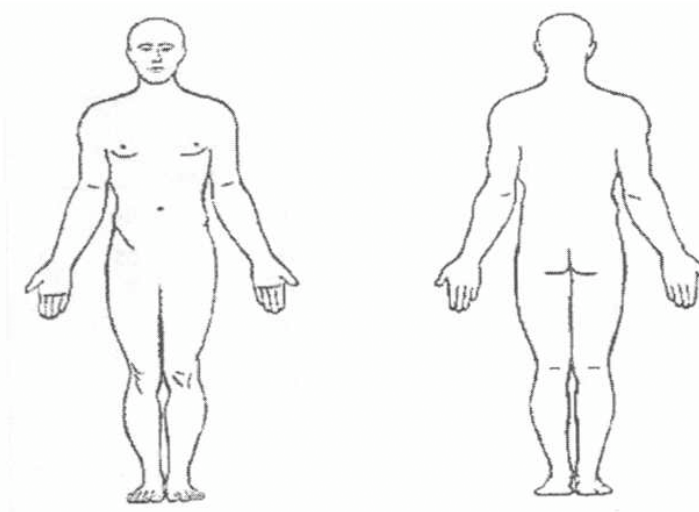
Regular exercise activities _____

Check any of the following that apply to your current health:

Pregnancy Heart conditions Blood clots Diabetes
 Infections Cancer Difficulty breathing Arthritis

Previous surgeries, injuries, and major illnesses and dates of _____

Mark areas of pain on the figures below:



I know that massage is not a substitute for medical examination or care. I have stated all of my known medical conditions and will inform Kate of any changes in my health status.

Signature _____