Holistic Massage

of Cape Cod

HEALTH INFORMATION SHEET

Personal Information

Name:_____ Age:_____ DOB:_____

Adress:_____ Phone:_____

City/State/Zip:_____

Employer/ Occupation:_____

Hobbies/Physical Activities:_____

How did you hear about us? _____

E-mail:_____

Preferred method of contact? ☐ e-mail ☐ phone

Date:_____

Massage History Information

Have you received a professional massage before? ☐ YES / ☐ NO

If yes , what type:_____How Often:_____ Date of last massage:_____

Depth of massage pressure preferred: ☐ Light ☐ Moderate ☐ Firm ☐ Deep

What are your expectations from this massage session? _____

_____

Please feel free, at any time, to communicate to the therapist any information about the comfort or discomfort of the pressure or techniques being used. Either party may terminate the massage at any time, for any reason.

Medical History

Do you have or have you had any of the following:

Current	Previous	Condition	Current	Previous	Condition
☐	☐	Acute Infections Disease	☐	☐	Hernia
☐	☐	Allergies :_____	☐	☐	Insomnia
☐	☐	Arthritis- Osteoarthritis	☐	☐	Irritability/nervousness/stress
☐	☐	Arthritis - Rheumatoid	☐	☐	Muscle Cramps / Spasms
☐	☐	Asthma / Respiratory	☐	☐	Neck Pain
☐	☐	Back Pain	☐	☐	Numbness / Tingling
☐	☐	Blood Clots / Phlebitis	☐	☐	Osteoporosis
☐	☐	Bruise Easily	☐	☐	Poor Circulation
☐	☐	Cancer	☐	☐	Poor Posture

☐	☐ Cold / Flu	☐	☐ Skin Problems
☐	☐ Chest Pain	☐	☐ Stroke
☐	☐ Diabetes	☐	☐ Swollen Ankles
☐	☐ Disk Problems	☐	☐ Swollen Joints
☐	☐ Dizziness	☐	☐ Tendonitis
☐	☐ Earache / Ringing in Ears	☐	☐ Tremors
☐	☐ Headache	☐	☐ Varicose Veins
☐	☐ Foot Problems	☐	☐ HIV
☐	☐ Others:_____		

Are you pregnant? ☐ YES / ☐ NO

Are you currently under the care of a health practitioner? ☐ YES / ☐ NO

If yes please explain: _____

Please list current prescription and over the counter medications and their associated condition:

_____

Any heart condition? _____Blood Pressure: ☐ Low ☐ Normal ☐ Hight

Have your been hospitalized or had surgery within the past 2 years ? ☐ YES / ☐ NO

If yes please explain: _____

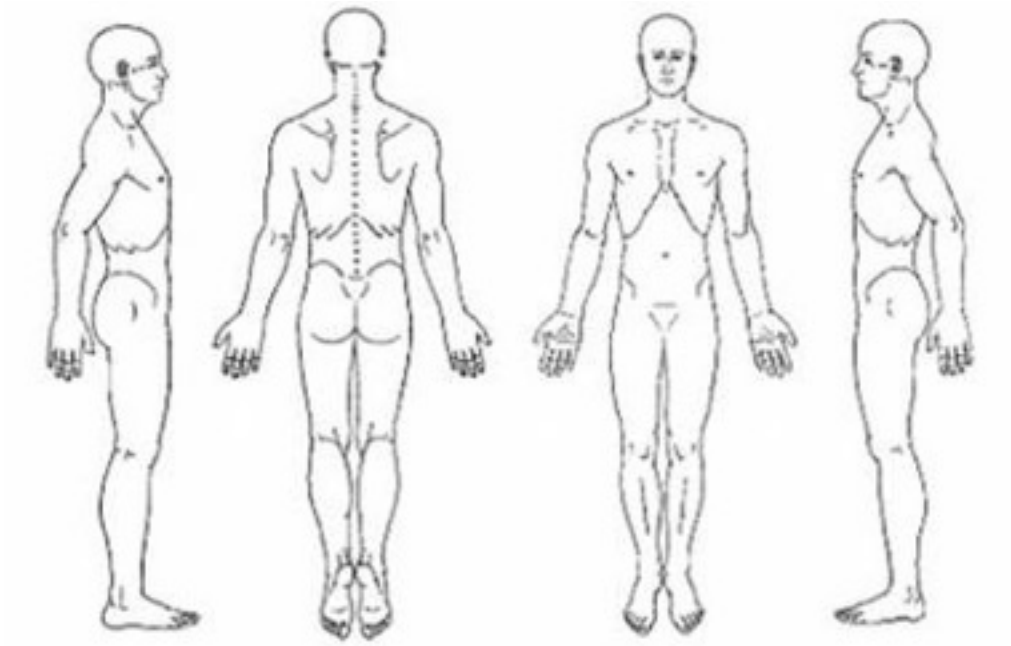
Have you had any recent injury, serious illness, or are you suffering from a chronic condition?

☐ YES / ☐ NO

If yes please explain: _____

Are you wearing any of the following : ☐ Hard Contact lenses ☐ Hearing Aid ☐ Pace Maker

Please indicate on the diagrams the area(s) where you are experiencing muscle and/or bodily discomfort and/or pain:



Which areas require extra focus? _____
Which areas should be avoided? _____

The undersigned stipulates the following:

1. I am solely responsible for my physical condition and for for seeking medical treatment when necessary;
2. I acknowledge that the intent of the massage is not to diagnose or treat illnesses;
3. I further authorize permission to contact my primary health care provider for information pertaining to my health and safety regarding massage;
4. All sessions are conducted in a professional Non-sexual manner, any sexual remarks or advances will result in immediate termination of the session.
5. I understand that the massage I receive is for relaxation, stress reduction, and relief of muscular tension and if I experience any pain or discomfort I will inform the practitioner immediately.

Signature:_____Date:_____