PATIENT INFORMATION	rease use in order of importance your areas of concern and symptoms.
Please Print Clearly Today's Date:	
Gender:   Male   Female Birthdate:  Address:	Are you currently working with and receiving treatment from a medica doctor or practitioner? If yes, please explain. □ Yes □ No
City: State: Zip:	
Email:	
Referred By:	Are you currently seeing a psychotherapist or are you attending regular support group meetings? If yes, please explain. □Yes □No
□Home □Cell □ Work Phone:	
Occupation:	List stress reduction and exercise activities. Include frequency.
If medically necessary do I have your permission to consult with your primary care physician,? □Yes □No  Primary Care Physician:	List prescribed medications and over the counter drugs, dietary
Primary Care Physician Phone Number:	supplements (including vitamins and herbal supplements, etc) that you are currently taking.
Emergency Contact:	
Emergency Contact Phone Number:	
MASSAGE HISTORY/TREATMENT INFORMATION	
Have you received a professional massage before? □Yes □No	HEALTH HISTORY
If yes, frequency Date of last massage  What results do you want from your massage session?	Please include date and treatment received for surgeries or accidents:
Please check the areas of your body that you give permission to receive massage today:	Do you currently have any infectious diseases (i.e. cold, flu, HIV, hepatitis, etc) and if yes, please explain. ☐Yes ☐No
□Head □Face □Neck □Arms / Hands □Chest/Pecs	
□Abdomen □Back □Glutes / Hips □Legs / Feet	

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		headaches			head injuries, concussions			
		A STATE OF A SECTION AND A SECTION OF THE SECTION O			dizziness, ringing in the ears			
	100000	fatigue			loss of memory, confusion			
					numbness, tingling			scoliosis
		fever			sciatica, shooting pain			broken bones
		sinus						spinal problems
		depression						
					herpes / shingles			
					other			
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