ractitioner/Clinic Name:		_ Health Information	
ontact Information:		(page 1 of 2	
Client Contact Information Client Name: Date of Birth:			
Address:			
Phone:			
Referred by:			
		Phone:	
Physician/Health-care Provider			
Is this massage/bodywork med	lically necessary (is it fo	or a medical condition, injury, surgery)? Yes ☐ No ☐	
Do you have a physician referr	al/prescription? Yes	s □ No □	
Type of insurance coverage for		s □ No □ If yes, please complete the Billing Information form on Worker's Compensation Private Health	
Massage Information Have you ever received profes How recently?			
What types of massage/bodyw			
What kind of pressure do you p	orefer? Light	Medium Firm	
How do you feel today?			
List and prioritize your current	symptoms/issues (stres	es, pain, stiffness, numbness/tingling, swelling, etc.):	
Do these symptoms interfere w Explain:	rith your activities of dai	ily living (e.g., sleep, exercise, work, childcare)? Yes No	
List the medications you currer	ntly take:		
Are you wearing contacts?	Yes □ No □		
Are you wearing dentures?	Yes □ No □		
Are you wearing a hairpiece?	Yes □ No □		
Are you pregnant?	Yes □ No □		



Health History Have you had any injuries or surgeries in the past that may influence today's treatment?  Circle any of the following health conditions that you currently have (if you are unsure, please ask): blood clots, infections, congestive heart failure, contagious diseases, pitted edema Please answer honestly, as massage may not be indicated for the above conditions.  Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received: Current Past Muscle or pinit stiffness	Practitioner/Clinic Name:		Clinic Name: Hea	<b>Health Information</b>	
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J	Client S	Signature	9:	Date:	
Parent or Guardian Signature (in case of a minor):	Client Signature: Parent or Guardian Signature (in case of a minor):			Date:	

