First Name ______________________

Last Name ______________________

Date of birth ______________________

Referred by ______________________

Email Address ______________________

Home Phone # ______________________

Mobile Phone # ______________________

Work Phone # ______________________

Street Address ______________________

State ______________________

City ______________________

Zip Code ______________________

Emergency contact name ______________________

Emergency contact relationship ______________________

Emergency phone # ______________________

Physician's name ______________________

Physician's phone # ______________________

Date of initial visit ______________________

How would you rate your general health?

○ Excellent ○ Good

○ Fair ○ Poor

Have you had a professional massage before?

○ Yes *(Date of last treatment)* ______________________

○ No

List current medications & the conditions they are treating

____

List any major accidents or surgeries (including dates)

____

Please tell us about any allergies or hypersensitivities

____

Reason for initial visit

____

Signature: ______________________ Date: ______________________