Heartline
Massage Therapy

Welcome to Heartline Massage Therapy

Confidential Patient History

Name_____ Phone (am) _____-_____ (pm) _____-_____
Address_____ City_____ State_____ Zip _____
Date of Birth_____ Age____ Sex____ email_____
Occupation_____Employer_____
Hobbies/Sports_____

Have you ever received massage/bodywork before? _____ How often? _____
Referred by_____

Please list any prescription drugs you are currently taking and the purpose of these:

_____

_____

Are you currently under the care of a medical doctor, chiropractor, or other health care provider?_____
If so, please explain why:_____

_____

Do you have a history of any of the following? (please check all that apply)

____ high blood pressure	____ muscle sprain/strain	____ blood clots	
____ low blood pressure	____ stroke	____ heart attack	
____ neck pain	____ headaches	____ arthritis	____ back pain
____ fibromyalgia	____ surgery	____ diabetes	____ cancer
____ car accident	____varicose veins	____ bursitis	____ HIV/AIDS
____ allergies to oils	____ hypoglycemia	____ pregnant (now)	
____ chronic fatigue syndrome	____ use of tobacco	____ other :_____	

Please list areas that you carry tension, soreness, or pain (chronically, or recently):

_____

_____

Do you have any of the following today?

____ sunburn	____ inflammation/swelling	____ headache	____cold/flu	
____ skin rash	____ open cuts	____ bruises	____ burns	____ severe pain

What results are you expecting of your massage therapy session?

_____

In case of emergency please contact:

_____
Name Phone No. Relationship

All massages are therapeutic only and completely non-sexual.
Please give 24 hours notice if you need to cancel an appointment.
Full payment is expected for missed appointments.

Signature_____ Date _____