Welcome to Heartline Massage Therapy

Confidential Patient History

Name_______________________________ Phone (cell) _______-________ (work) ______-________

Nickname/preferred first name___________________________

Address_________________________________ City________________ State______ Zip _________

Date of Birth____________ Age_____ 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 ________________