Today's Date:___________________________

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Patient Care Information Form

Name:____Date of Birth:_________________________

Address: ____

Phone Number(s): ____Occupation:______________

Email address:____

Emergency Contact: ____Phone: ___________________

Primary Physician: ____Phone:____________________

The following information will be used to help plan safe & effective massage sessions.
Please answer the questions to the best of your knowledge.

How would you rate your general health? ___________________________

Do you have any previous experience with Massage Therapy? ________Last treatment date:________

Is there a particular area of the body where you are experiencing tension, stiffness, pain, discomfort?

____

Are you currently under medical supervision? If so, please describe the reason:

____

List current medications & conditions they are treating:

____

List any accidents &/or surgeries:

____

____

Is there anything about your health history that you think would be useful for your massage practitioner to know to plan a safe & effective massage sessions for you:

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