Wholistic Touch Confidential Health Information

Welcome. I want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your session, please call 797-1084.

Name _____ Cell/Home #_____ Cell/Work# _____

Address _____ City_____ State _____ Zip_____

Email _____

Date of Birth_____ Age _____ M ☐ F ☐ Marital Status _____

Occupation _____ Referred by _____

Have you ever received massage therapy? Yes ☐ No ☐

Type of massage experienced: ☐ Deep Tissue ☐ Swedish ☐ Other _____

Are you taking medication?_____ Describe _____

_____

Have you consumed alcohol in the past 24 hours? Yes ☐ No ☐

Do you have a history of the following?

- ☐ accident
- ☐ neck pain
- ☐ whiplash
- ☐ headaches
- ☐ disk problems
- ☐ mid back pain
- ☐ joint ache
- ☐ decreased range of motion
- ☐ broken bones
- ☐ sprains
- ☐ seizures
- ☐ abdominal pain
- ☐ nervous tension
- ☐ arthritis, bursitis or gout
- ☐ allergies to oils or perfumes
- ☐ wear contacts or other prosthesis
- ☐ surgery
- ☐ fibromyalgia
- ☐ breast augmentation
- ☐ diabetes
- ☐ varicose veins
- ☐ high blood pressure
- ☐ stroke
- ☐ heart attack
- ☐ cancer
- ☐ lymph node removal
- ☐ radiation
- ☐ head trauma
- ☐ any family member with lymphedema
- ☐ colitis
- ☐ HIV

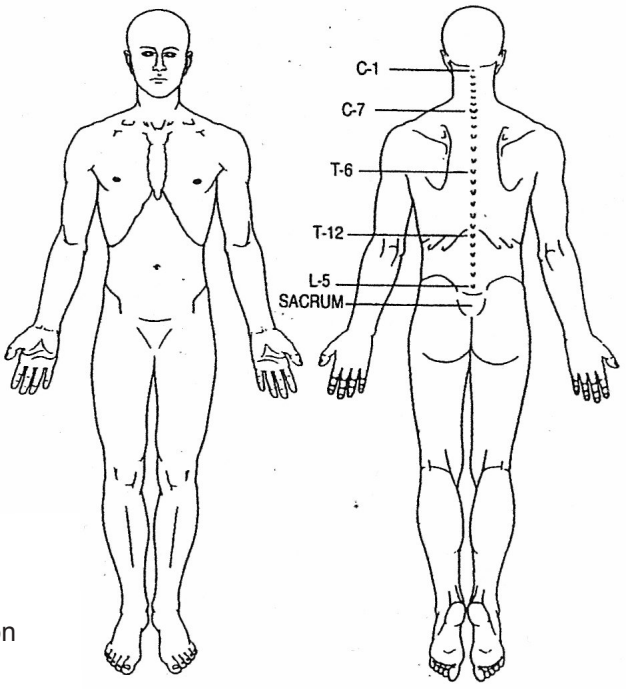
Do you have any of the following today?

- ☐ sunburn
- ☐ inflammation
- ☐ severe pain
- ☐ headache
- ☐ open cust, bruises, burns
- ☐ irritate skin rash
- ☐ poison ivy
- ☐ cold/flu

Please indicate if your consumption is:

	None	Light	Moderate	Heavy
salt	☐	☐	☐	☐
sugar	☐	☐	☐	☐
caffeine	☐	☐	☐	☐
tobacco	☐	☐	☐	☐
alcohol	☐	☐	☐	☐
exercise	☐	☐	☐	☐
water	☐	☐	☐	☐

Please indicate the places you are feeling discomfort with an X.



Please read the following and sign below:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

Date: _____ Signature: _____