Diane Stakoe, LMBT #7499 Therapeutic Massage Therapy

Name____

Address____Primary Phone:____________________

City/State/Zip____

Email____ Date of Birth________________________

How did you hear about this practice?____

Reason for seeking massage therapy?____

What do you hope to accomplish from your session(s)?____

____

Describe your weekly activities and how they affect your body (i.e. occupation, hobbies)

____

____

Check the following exercises you practice regularly:
□ biking □ walking □ running □ martial arts □ swimming □ yoga □ pilates
□ dance □ weight-training □ team sports □ house/yard work □ other___________________________

How many hours of sleep do you get per night? □ <5 □ 5-6 □ 6-7 □ 7-8 □ 8-9 □ more than 9

Have you had any surgery or hospitalization? □ more than 10 years ago □ 5-10 years ago □ less than 5 years ago

Have you ever been involved in an injury or accident?
□ more than 10 years ago □ 5-10 years ago □ less than 5 years ago

Do you consider that you have recovered from these events? □ yes □ no

Do you have any chronic, ongoing conditions that you deal with on a regular basis?
□ yes □ no If yes, please explain____
____

Please check off any of the following conditions or symptoms which apply to you now or in the past:

___Allergy to nuts or nut oils
___Arthritis
___Blood Clots
___Bursitis
___Contagious Conditions
___Diabetes
___Headaches
___Heart Attack / Stroke
___High Blood Pressure
___Hypo or Hyperglycemia
___Low Back Pain
___Low Blood Pressure
___Muscle Sprain / Strain
___Osteoporosis
___Currently Pregnant____Baby's Due Date
___Skin Infections / Conditions
___Varicose Veins
___Other Conditions

Are you taking any medication? □ yes □ no If yes, please list and explain:
____

Are you currently under the care of a doctor? □ yes □ no If yes, please explain____________________________
____

May I have permission to contact your Doctor/Therapist? □ yes □ no
Doctor /Therapist name____ Phone________________________________

I have completed this health form to the best of my knowledge. I understand that massage services are a therapeutic health aid. They do not take the place of a physician's care when indicated. Any information exchanged during a session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call as soon as possible to reschedule my appointment.

If I miss a scheduled appointment without giving 24 hours notice, I agree to pay any missed appointment fee applicable.

Name (signature)____Date_________________________