

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 visit, please call 797-1084.

Name _____ Home # _____ Work # _____

Address _____ City _____ State _____ Zip _____

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?

- | | | |
|--|--|--|
| <input type="checkbox"/> accident | <input type="checkbox"/> sprains | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> seizures | <input type="checkbox"/> breast augmentation |
| <input type="checkbox"/> whiplash | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> headaches | <input type="checkbox"/> nervous tension | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> disk problems | <input type="checkbox"/> arthritis, bursitis or gout | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> allergies to oils or perfumes | <input type="checkbox"/> stroke |
| <input type="checkbox"/> joint ache | <input type="checkbox"/> wear contacts or other prosthesis | <input type="checkbox"/> colitis |
| <input type="checkbox"/> decreased range of motion | <input type="checkbox"/> surgery | <input type="checkbox"/> colitis |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> surgery | <input type="checkbox"/> HIV |

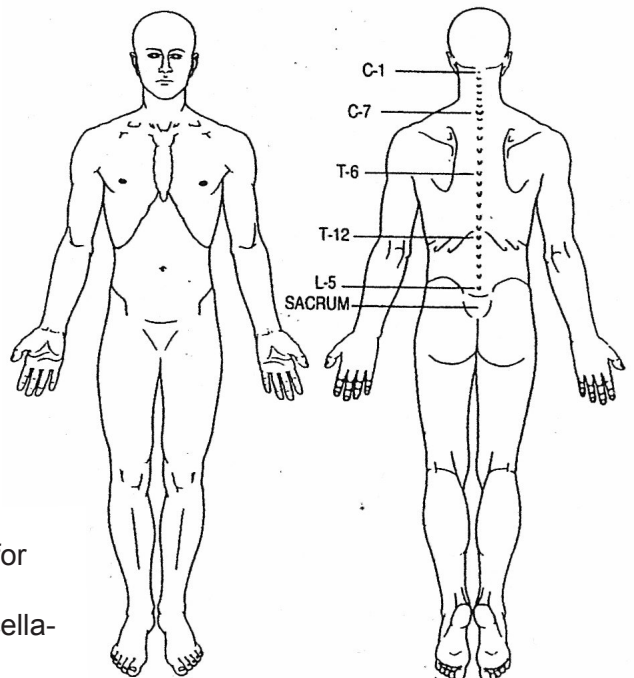
Do you have any of the following today?

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> sunburn | <input type="checkbox"/> open cut, bruises, burns |
| <input type="checkbox"/> inflammation | <input type="checkbox"/> irritate skin rash |
| <input type="checkbox"/> severe pain | <input type="checkbox"/> poison ivy |
| <input type="checkbox"/> headache | <input type="checkbox"/> cold/flu |

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

Please indicate if your consumption is:

- | | None | Light | Moderate | Heavy |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|
| salt | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sugar | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| caffeine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| water | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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: _____