

LARGE PRINT HEALTH FORM

Name: _____ DOB: _____

Address: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____

Emergency Contact: _____

Phone: _____

How did you hear about this place:

*Have you received a professional
massage before? _____

***Are there any areas of your body
that you 'do not' want massaged:**

(Face) (Scalp) (Neck) (Upper Chest) (Shoulders)
(Stomach) (Upper back) (Mid back) (Lower back)
(Arms) (Hands) (Gluteals) (Legs) (Feet)

*Please list any surgeries you have had in
the past _____

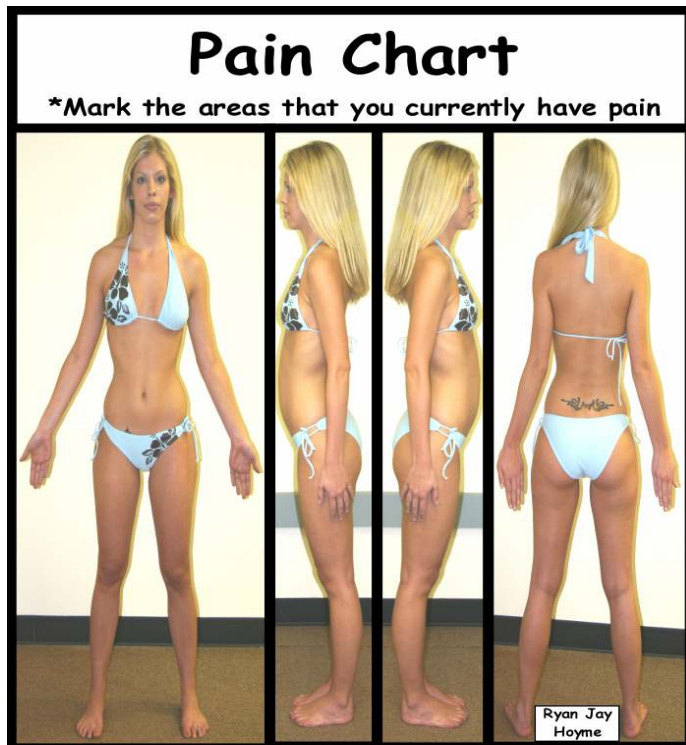
*Please list any accidents you have had in the
past _____

*Please list any allergies you have _____

*Please list any diseases you have _____

*List any medications you are currently on? _____

*Is there anything else I should know about _____



I have stated all conditions that I am aware of and that this information is true and accurate to the best of my knowledge. I agree to inform my massage therapist immediately of any change in conditions as stated above. I acknowledge that this information is confidential and intended for review by fellow massage therapists; that a medical referral may be requested of me; and that "This place of business" is not held liable for the management or arising of conditions.

Signature: _____ Date: _____