



Therapeutic & Stress Reduction Massage

Erin Howk, NCTMB
Nationally Certified Massage Therapist



CONTACT INFORMATION

NAME _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

PHONE _____ CELL _____ EMAIL _____

EMERGENCY CONTACT _____ PHONE _____

WHOM MAY I THANK FOR REFERRING YOU? _____

HEALTH HISTORY INFORMATION

BIRTHDATE ____/____/____ AGE _____ HEIGHT _____ WEIGHT _____ M F

OCCUPATION _____ PT FT

DO YOU HAVE ANY ALLERGIES THAT MAY BE FOUND IN MASSAGE LOTIONS OR OIL? Yes No

If so, what type? nuts/soy/milk/other _____

ARE YOU PREGNANT? YES NO IF YES, WHEN ARE YOU DUE? _____

HAVE YOU RECEIVED MASSAGE IN THE PAST? YES NO Relaxation/Deep Tissue/Other _____

DO YOU HAVE ANY OF THE FOLLOWING TODAY? Yes No

- sunburn
- inflammation
- severe pain
- headache
- cut, burns, bruises
- irritated skin rash
- fever
- cold, flu

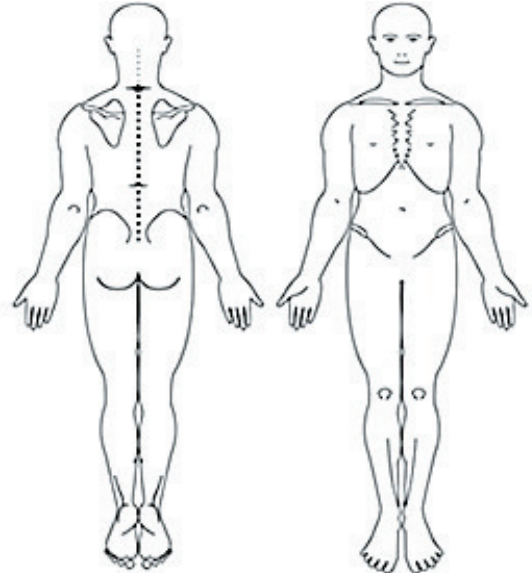
HOW MANY HOURS PER WEEK DO YOU PARTICIPATE IN ACTIVITIES OR SPORTS?

- Less than one hour
- 1-2 hours
- 3-4 hours
- 5 or more hours

WHAT ARE YOUR GOALS FOR MASSAGE?

- relaxation
- injury rehabilitation
- high activity level/maintenance massage
- other _____

SHADE IN ANY AREAS WHERE YOU ARE FEELING DISCOMFORT



ARE THERE ANY OTHER HEALTH CONDITIONS OR MEDICATIONS I SHOULD BE AWARE OF? Yes No

PLEASE LIST: (Past or recent surgeries, illness, conditions, medications, injuries, accidents - even if you feel you were not injured)

I understand that massage therapy is not a replacement for medical care and that no diagnosis will be made. I have stated all my known medical conditions and I understand it is my responsibility to keep my massage practitioner informed of any changes in my health and/or medications I take in the future.

SIGNATURE _____ DATE _____