actitioner/Clinic Name:		_ Health Informatio	
ontact Information:			
Client Contact Information Client Name: Date of Birth:			
Address:			
Phone:			
Referred by:			
		Phone:	
Physician/Health-care Provider			
Is this massage/bodywork med	lically necessary (is it for a	a medical condition, injury, surgery)? Yes ☐ No ☐	
Do you have a physician referra	al/prescription? Yes [□ No □	
		□ No □ If yes, please complete the Billing Information form Worker's Compensation Private Health	
Massage Information Have you ever received profess How recently?			
What types of massage/bodyw	ork do you prefer?		
What kind of pressure do you p	orefer? Light	Medium Firm	
How do you feel today?			
List and prioritize your current s	symptoms/issues (stress,	pain, stiffness, numbness/tingling, swelling, etc.):	
Do these symptoms interfere w Explain:	ith your activities of daily	living (e.g., sleep, exercise, work, childcare)? Yes No	
List the medications you curren	ntly take:		
List the medications you curren	ntly take:		
Are you wearing contacts?	Yes No		



Health History Have you had any injuries or surgeries in the past that may influence today's treatment? Circle any of the following health conditions that you currently have (if you are unsure, please ask): blood clots, infections, congestive heart failure, contagious diseases, pitted edema Please answer honestly, as massage may not be indicated for the above conditions. Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received: Current Past Muscle or pinit stiffness	Practitioner/Clinic Name:		Clinic Name: Hea	lealth Information	
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