MASSAGE ASSOCIATES HEALTH SCREEN

Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Please provide best phone number: _____

Email: _____

Referred by/How did you hear about us? _____($10 off to your referrer)

Occupation: _____

Have you ever had a professional massage: Yes ____ No ___ How long since last massage: _____

Reason for your visit (relaxation, pain relief, etc.); any specific areas of tension/concern?

_____

Emergency Contact: _____ Phone: _____

Medical Information

Please make us aware of any medical conditions you may have. Include any recent rashes, breaks, sprains, surgeries or illnesses.

Are you currently under medical care? _____ If yes, please provide a brief reason.
Medical conditions:

_____

Medications and their use:

_____

Is there any chance you are pregnant? Yes_____ No_____ Due date: _____

Do you have any allergies? Yes_____ No_____ Allergen(s):_____

I authorize Massage Associates to contact me by one or both of the following methods. Check below.

Text Message: Yes _____ Email: Yes _____

PLEASE READ AND SIGN
I have read the preceding information and understand it is my responsibility to inform the therapist of any of my health changes and issues prior to each session. I understand that this work does not constitute medical treatment. Appointments canceled with less than 24 hours notice will be charged the full service fee. The therapist may refuse service at any time.

Signature: _____ *Date:* _____