MASSAGE ASSOCIATES - HEALTH SCREEN

Name: _____ DOB: _____ Age: _____

Address: _____

City: _____State: _____ Zip: _____

Please provide best contact number: cell / office / home _____

Email: _____ Referred by _____

Occupation: _____ Have you ever had a professional massage: Yes __ No ___

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

_____

Emergency Contact: _____ Phone: _____

Medical Information

Are you currently under medical care? _____ If yes, please provide brief reason below.

Medical conditions? Medications and their use? Any allergies - if yes to what?

_____

_____

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

Have you had a fever in the last 24 hours of 100 degrees F or above? Yes _____ No_____

Do you now, or have you recently had, any respiratory or flu symptoms, sore throat or shortness of breath? Yes_____ No_____

Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19, or has coronavirus-type symptoms? Yes_____ No_____

If you answered yes to any of the above three questions on your day of service we will be unable to offer you massage on that day.

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 cancelled with less than 24 hours notice will be charged a $50 fee. The therapist may refuse service at any time.

Signature: _____ Date: _____