Health Information Form

Please print clearly and complete the entire form. This information will be used to construct a customized treatment plan for your session. All information disclosed is kept strictly confidential.

Name _____ Date _____

Address _____
Street *city* *state* *zip*

Phone: Cell _____Other: _____

Email _____ *this will only be used to inform you of promotions and/or health information.*

Male/Female Date of Birth_____

Occupation_____

Have you ever had a therapeutic massage before? Yes/No

What types of physical activity are you involved in?_____

Are you currently under a physician's care? Yes/No
If yes, for what condition?_____

* Please see other side *