HEIDI CREIGHTON

Licensed Massage Therapist

Confidential Client Health Information

Name:_____Date of Birth_____
Address:_____
Phone:_____E-Mail:_____
Occupation:_____Referred by:_____

Are you currently under the care of a health care practitioner? _____If yes, please explain_____

Are you currently taking any medications?_____
_____

History of illnesses, injuries, and/or surgeries:_____
_____

Any other health conditions I need to be made aware of?_____
_____

Any allergies or skin conditions?_____
_____

Have you ever had a professional massage before ?_____How long ago?_____

Circle any of the following areas of pain that you have or have had in the past year:

Headaches Back Chest Abdomen Hip Leg Shoulder Neck

Arm Pelvis Groin Buttock

Where in your body do you feel the effects of stress?_____
_____

What do you do for relaxation and exercise?_____
_____

Please circle the areas of your body that you give permission to receive massage:

Back Legs Buttocks Arms Abdomen Chest Neck Head

Face Feet

Prioritize the areas of your body that you prefer to be massaged_____
_____

I understand that massage therapists do not diagnose illness or disease. It is made clear to me that massage is not a substitute for professional diagnoses and that I see a physician for any physical ailment that I may have. I have stated all my known medical conditions and take it upon myself to keep Heidi updated on my physical health. I also understand that payment by cash or check is due at time of treatment and full payment may be expected if cancellation of appointment is less than 24 hours.

Signature: _____ Date:_____