Patient Name: ____ Date Of Birth: _____/_____/_____ Sex: M F

Home Phone: (_____)______-________ Cell Phone: (_____)______-________ Work Phone: (_____)_____-________

Mailing Address: ____ City/State:___________________________

Zip: ________________ Email:____

Were you referred by a doctor? **Y N** If yes, Physician:_________________________ Clinic Phone: (_____)_____-_______

Have you ever had a professional massage? **Y N** Do you have any concerns about your massage treatment? **Y N**

Would you like us to check your insurance to see if they cover massage therapy? **Y N** *(if yes, please ask for billing form)*

Medical Information

Please circle **'P'** for past medical condition in the last 5 years or **'C'** for current medical conditions.

P C	Chronic Headaches	P C	Arthritis or Joint Swelling	P C	Numbness or Stabbing Pain
P C	Chronic Stress	P C	Vertigo or Dizzy Spells	P C	Epilepsy or History of Seizures
P C	Pregnancy	P C	Hyper/Hypoglycemia	P C	Neurological Disorders
P C	Insomnia	P C	Allergies	P C	High / Low Blood Pressure
P C	Bruise Easily	P C	Skin Rashes / Lesions	P C	Fungal Infections
P C	Vericose Veins	P C	Nerve Damage/Impingement	P C	Blood Clots or Disorders
P C	Cancer	P C	Broken / Fractured Bones	P C	Joint / Muscle Pain

Please list all current health conditions or concerns not listed above:

____

Please list current medications:____

I have provided Wellness Bodywork with accurate health information and agree to notify Wellness Bodywork of any changes to my health history prior to receiving any massage services. I will immediately inform my massage therapist if I experience any discomfort during my massage treatment so that the massage may be adjusted to my comfort. Massage therapy is provided for the basic purpose of relief of muscular tension and I will contact a qualified medical practitioner or primary care provider if I have any questions or concerns regarding massage or my health. INITIAL: ____________

The massage therapists at Wellness Bodywork are all individually licensed by the Washington State Health Department. Should any concerns regarding my treatment arise, I will report my concerns immediately, and they will be handled with my massage practitioner directly and individually.

Patient Signature:____Date:_____/_____/_______