CONFIDENTIAL INFORMATION

WELCOME! IN ORDER TO BETTER MEET YOUR NEEDS,
PLEASE TAKE A MOMENT TO FILL OUT THIS FORM. ALL INFORMATION IS CONFIDENTIAL.

NAME _____ HOME #_____ WORK #_____

ADDRESS _____ CITY_____ STATE_____ ZIP_____

OCCUPATION _____

HOW DID YOU HEAR ABOUT THIS PRACTITIONER? _____

DATE OF BIRTH_____ M F EMAIL _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY BEFORE? YES NO

WHEN WAS YOUR LAST MASSAGE? _____

TYPE OF MASSAGE EXPERIENCED? _____

ARE YOU PREGNANT? YES NO

WHAT MEDICATIONS ARE YOU TAKING? _____FOR WHAT?_____

LIST OTHER PRACTITIONERS YOU USE FOR HEALTH CARE _____

REASON(S) FOR YOUR APPOINTMENT TODAY _____

HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? YES NO QTY?_____

DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING?

- ☐ accident
- ☐ neck pain
- ☐ whiplash
- ☐ headaches
- ☐ disk problems
- ☐ mid back pain
- ☐ low back pain
- ☐ joint ache
- ☐ decreased range of motion
- ☐ stress
- ☐ sprains
- ☐ seizures
- ☐ abdominal pain
- ☐ nervous tension
- ☐ arthritis, bursitis or gout
- ☐ allergies to oils or perfumes
- ☐ surgery
- ☐ fibromyalgia
- ☐ TMJ
- ☐ depression
- ☐ colitis
- ☐ abuse survivor
- ☐ *diabetes – (can you cut your own toe nails?)*
- ☐ *varicose veins*
- ☐ *broken bones within 2 years*
- ☐ *tumors*
- ☐ *bleeding (not menses)*
- ☐ *cancer*
- ☐ *fever*
- ☐ *high blood pressure*
- ☐ *stroke*
- ☐ *osteoporosis*
- ☐ *HIV*
- ☐ *easy bruising*
- ☐ *heart attack*
- ☐ *atherosclerosis/arteriosclerosis*
- ☐ *chronic pain*
- ☐ *thrombophlebitis*
- ☐ *skin lesions/open sores*
- ☐ *skin infections*
- ☐ *severe pain*
- ☐ *contact lenses*
- ☐ *herpes*
- ☐ *numbness*
- ☐ *inflammation*
- ☐ *fatigue*
- ☐ *substance abuse*
- ☐ *ulcers*
- ☐ *anticoagulant drugs*
- ☐ *post-op*
- ☐ *peritonitis (abdominal bleeding)*
- ☐ *elderly*

PLEASE INDICATE IF YOUR CONSUMPTION IS:

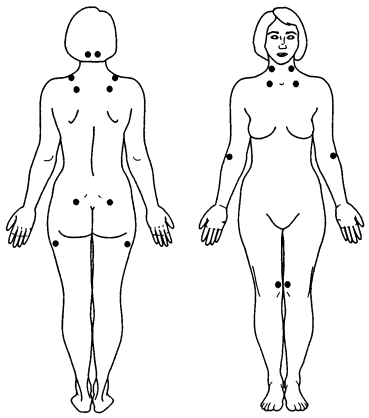
	None	Light	Medium	Heavy
salt	☐	☐	☐	☐
sugar	☐	☐	☐	☐
caffeine	☐	☐	☐	☐
tobacco	☐	☐	☐	☐
alcohol	☐	☐	☐	☐
water	☐	☐	☐	☐

exercise/stretching choice and frequency: _____

_____

_____

PLEASE CIRCLE YOUR AREAS OF DISCOMFORT



Please continue on other side…

FOR PREGNANT LADIES ONLY!

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

- ☐ pregnancy with twins (or other multiples)
- ☐ previous miscarriage
- ☐ pre-term labor
- ☐ suspicion of pre-eclampsia
- ☐ high blood pressure
- ☐ eclampsia
- ☐ gestational diabetes
- ☐ varicose veins
- ☐ nausea
- ☐ vaginal bleeding/spotting
- ☐ uterine cramping
- ☐ puffiness or edema
- ☐ other discomforts

IS THIS YOUR FIRST PREGNANCY? YES NO

WHAT IS YOUR DUE DATE?_____ TRIMESTER?_____

ARE YOU EXPERIENCING ANY COMPLICATIONS? YES NO

IF YES, PLEASE DESCRIBE _____

_____

WHO IS YOUR PRENATAL CARE PROVIDER? _____

PHONE NUMBER _____ MAY I CONTACT HIM/HER IF NECESSARY? YES NO

PLEASE READ THE FOLLOWING AND SIGN BELOW:

- I understand that the massage practitioner does not diagnose and that massage is not a substitute for medical care.
- I will immediately inform the practitioner if her touch is in any way uncomfortable.
- I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.
- I take full responsibility for my health, and my signature on this form releases Hope Haviland from any liability as a result of the massage. I certify that I am acting in my personal capacity.
- I understand that I am responsible to pay for cancelled appointments made under 24 hours notice.

SIGNATURE _____ DATE:_____

CONSENT TO TREATMENT OF MINOR: By my signature below, I authorize Hope Haviland to administer massage and bodywork techniques to my child or dependent as she deems necessary.

Signature of Parent or Guardian: _____ DATE:_____