

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: _____