

Seattle Massage Confidential Patient Information Form

Name: _____
Address: _____
Home Phone: _____
Occupation: _____
Employer: _____
Physician: _____
Emergency Contact: _____
Referred By: _____

Birth Date: _____ Sex: _____ Age: _____
City/State/Zip: _____
Email: _____
Work Phone: _____
City/State/Zip: _____
City/State/Zip: _____
Emergency Phone: _____

If using Health Insurance please fill out:

Name of Health Insurance Plan: _____ ID: _____ Number: _____
Do you have your Prescription today? () Yes () No
Employer: _____

- | | | |
|-----|-----|--|
| Yes | No | |
| () | () | Have you ever had a professional massage? What other ways do you relieve stress? |
| () | () | Any areas you wish not to be massaged? If yes, please describe: |
| () | () | Do you exercise regularly or participate in any sports? If yes, what kind/ how often? |
| () | () | Are you currently under the care of a physician or other health care provider for a specific condition? If yes, please describe: |
| () | () | Do you take any medication (including ibuprofen or aspirin)? If yes, please list medication, dosage and condition: |
| () | () | So you have skin problems or allergies? If yes, please describe: |
| () | () | Have you ever had surgery? If yes, please describe: |
| () | () | Do you have, or have you ever had heart problems? If yes, please describe: |
| Yes | No | |
| () | () | Do you have high or low blood pressure? If yes, circle one. |
| () | () | Do you have varicose veins, blood clots, or any other circulatory problem? If yes, please describe: |
| () | () | Do you have arthritis? If yes, circle what type: Osteoarthritis or Rheumatoid. Where is it located? |
| () | () | Do you have spinal problems? If yes, please describe: |
| () | () | Do you experience prolonged episodes of depression or other emotions? |
| () | () | Do you have an infectious or contagious disease? If yes, please describe: |
| () | () | Are you experiencing sleep disorders at this time? If yes, please describe: |
| () | () | Are you pregnant? _____ If so, what stage? _____ |
| () | () | Do you have any needs that require special attention? If yes, please describe: |
| () | () | Do you have any medical condition that I should be aware of before you receive a massage? _____ If yes, please describe: _____ |

I understand that massage practitioners do not diagnose illness, disease or other physical or mental disorders. Massage practitioners do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage and medical intuition is not a substitute for a medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health. Seattle Massage does not guarantee healing or lessening of pain.

24-hour notice is required for cancellations; failure will result in full payment.

Signature: _____
Signature: _____
(Signature by adult if client is under 18 years of age)

Date: _____
Date: _____