Care Touch Therapeutic Massage
P.O Box 343 Maple Valley WA 98038
(253) 397-8602
care-touch@comcast.net

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____

Day Phone: _____ Evening Phone: _____

Emergency Contact: _____ Phone: _____

Birthdate: _____ Male ☐ Female ☐

Have you received Massage before? Yes ☐ No ☐
What is your goals for this massage therapy session?
☐ Relaxation
☐ Stress relief
☐ Concern (such as pain): please list

_____

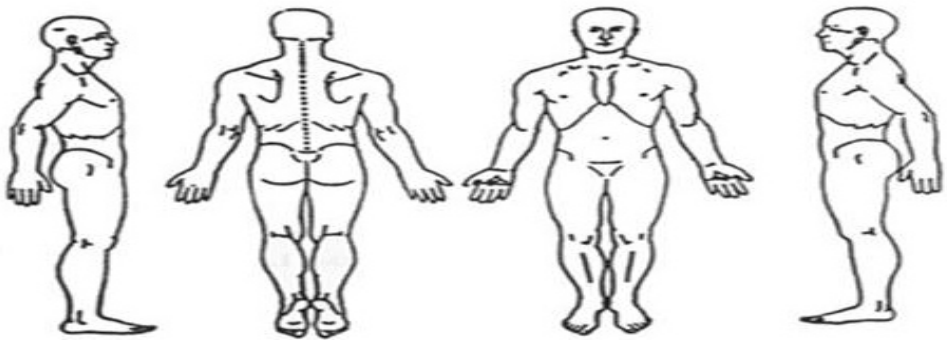
_____

List any regular activities you participate in: (i.e.: repetitive motion at work/home, exercise, hobbies)

_____

_____

Please circle areas of complaint:



Have you consumed alcohol in the last 24 hours? Y ☐ N ☐

Are you currently receiving medical care? Y ☐ N ☐

Diagnosis and treatment received:

_____

_____

List current care and current medications: _____

_____

_____

_____

It is important that your LMP learn to work safely.
Do you have a history of any of the following?

☐ Accident	☐ Sciatica	☐ Menstrual problems	
☐ Whiplash	☐ Varicose Veins	☐ Headaches	
☐ Diabetes	☐ Swollen Ankles	☐ Swollen legs	☐ Asthma
☐ Arthritis	☐ Fibromyalgia	☐ Heart Attack	☐ Tendonitis
☐ Chest Pain	☐ Blood Clots	☐ Sprains or Strains	☐ Osteoporosis
☐ Bursitis	☐ Broken Bones	☐ Scoliosis	☐ Stiff Joints
☐ High/Low BP	☐ HIV	☐ Herpes	☐ Cancer
☐ Athlete's foot	☐ Spasms/Cramps	☐ Spinal Problem	☐ Thyroid Problem
☐ Skin Rash	☐ Surgery	☐ Migraines	☐ Abdominal Pain
☐ Stroke	☐ Seizures	☐ Painful Joints	☐ Poor Circulation
☐ Epilepsy	☐ Numbness	☐ Warts	☐ Sinus

Others: _____

_____

Do you have any of the following today?

☐ Cold, Flu or Fever ☐ Open cuts or bruises

☐ Inflammation ☐ Sunburn ☐ Severe pain (where?)

☐ Blood clots ☐ Allergies (Oil/Lotions)

Are you Pregnant? Yes ☐ No ☐

If so, how far along? _____

Please read the following and sign below:

I have completed this information to the best of my knowledge and I understand that massage is not a replacement for medical care when it is so indicated.

I have stated all my medical conditions and take it upon myself to keep the LMP updated on my personal health.

There is a $20 cancellation fee if notice is not given at least 8 hours prior to your scheduled appointment. No shows may be charged in full.

I'll inform the LMP of any changes in my health that may occur during my course of treatment.

_____ _____

Signature Date