Heaven & Health
"Wellness On A Higher Level"

PERSONAL INFORMATION

Name _____ Phone (Primary) _____ Phone (Alt.) _____

Street Address _____ City/State/ZIP _____

Occupation _____ Email _____ DOB_____

Emergency contact _____ Relationship _____ Phone_____

How did you hear about us?_____

MEDICAL INFORMATION

Are you taking any medications? Y N
If so, please list:

_____

_____

_____

Do you have pain today? Y N
If yes, please explain:

_____

_____

_____

Pain scale today (please circle):

[Least] 1 2 3 4 5 6 7 8 9 10 [Most]

What makes it better?

___ Ice ___ Heat ___ Rest ___ Movement

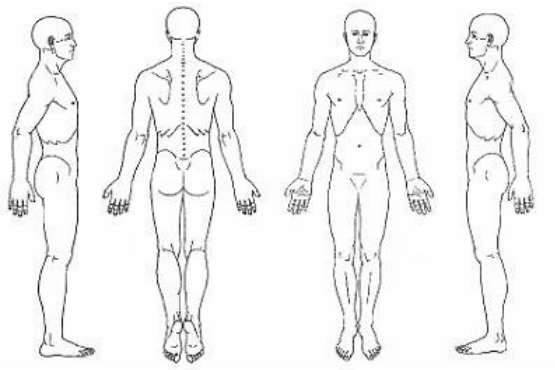
What makes it worse?

_____

Please indicate any of the following that apply to you:

____ Cancer
____ Headaches/Migraines
____ Arthritis
____ Joint Replacement(s)
____ Sprains/Strains
____ Allergies
____ Neuropathy
____ Fibromyalgia
____ Stroke
____ Heart Attack
____ Blood clots
____ Numbness
____ High/Low Blood Pressure
____ Surgeries
____ Recent injuries
____ Other _____

Please mark any areas of discomfort:



MASSAGE INFORMATION

Have you had a professional massage before? Y N
What pressure do you prefer?

____ Light ____ Medium ____ Deep

What type of massage are you seeking?

____ Relaxing ____ Therapeutic/Deep Tissue
____ Medical

Are there any areas you do NOT want massaged?
Please explain (feet, face, abdomen, etc.): _____

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

_____ _____

Client signature Date