Health Care Intake Form

You're Worth It! LLC
THERAPEUTIC MASSAGE

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell Phone _____

Email _____ Occupation _____

Birth date _____ Is this your first therapeutic massage? _____

In case of emergency contact: Name _____ Phone _____

Reason for coming for a massage:

❑ Relaxation ❑ Stress Reduction ❑ Athletic Enhancement ❑ Injury Recovery

Other _____

Please check any health conditions:

❑ High Blood Pressure	❑ Diabetes	❑ Cancer	❑ Carpal Tunnel Syndrome
❑ Heart Problems	❑ Skin Conditions	❑ AIDS	❑ Stiff Neck
❑ Diverticulitis	❑ Varicose Veins	❑ Headaches	❑ Back Pain
❑ Constipation	❑ Insomnia	❑ On Prescribed Blood Thinner	❑ TMJ Disfunction

Please list any other health conditions: _____

_____

_____

Injuries or surgeries: _____

_____

Are you presently under a Physician or Chiropractor's care? ❑ Yes ❑ No

If yes, please list name _____

Please indicate areas of tension or pain:

❑ face ❑ head ❑ neck ❑ shoulders ❑ arms ❑ hands ❑ back ❑ hips ❑ legs ❑ feet

When did pain or tension start? _____

Would you like to be on our mailing list? (We only use once or twice a year.) ❑ Yes ❑ No

How did you hear about us? _____