MASSAGE HEALTH PROFILE

NAME: ____ **DATE OF BIRTH:** __________________
E-MAIL ADDRESS: ____
ADDRESS: ____
PHONE #: ___________________________ **REFERRED BY:** __________________________________

MEDICAL HISTORY: CHECK ALL THAT APPLY

- o *Allergies*___________________________
- o *Arthritis*___________________________
- o *Asthma*___________________________
- o *Bleeding Disorder*___________________
- o *Blood Clots*_______________________
- o *Bone Disorders*_____________________
- o *Cancer**___________________________
- o *Disc Problems*______________________
- o *Diabetes*__________________________
- o *Edema*____________________________
- o *Fractures*__________________________
- o *Headaches/Migraines*________________
- o *Heart Attacks*_______________________
- o *Hearts Conditions*___________________
- o *High Blood Pressure*_________________
- o *Infection*__________________________
- o *Injuries*___________________________
- o *Low Blood Pressure*_________________
- o *Medications*________________________
- o *Pregnancy**________________________
- o *Psychiatric Disorders*________________
- o *Respiratory Disorders*_______________
- o *Skin Conditions*_____________________
- o *Sleep Disorders*_____________________
- o *Surgeries*__________________________
- o *Tendinitis*__________________________
- o *Varicose Veins*_____________________
- o *Vertigo*____________________________
- o *Other*_____________________________

PLEASE INDICATE IF YOU ARE COMFORTABLE WITH MASSAGE IN THESE AREAS (Y or N):

Abdomen ___ **Face** ___ **Feet** ___ **Gluteal Region** ___ **Head/Scalp** ___

Pectoral Region ___

I understand that the massage therapy that I am given is for purpose of stress reduction, relief from muscular tension, and/or improving circulation. I also understand that my therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorders, nor performs spinal adjustments/ manipulations purposely. I recognize that any information exchanged is for general education purposes only. I recognize that all the information I have provided my therapist will be used to enhance the quality of massage to fit my individual needs and will remain strictly confidential. I have filled out this health form to the best of my knowledge. I know that my failure to disclose any pertinent information may result in an unfavorable response, whether it may be an allergic reaction, disease, illness, or injury, which I hereby release my therapist and Skinfinite Solutions Wellness Spa LLC from any claims resulting from such. By signing below, I verify that I have read and agreed to all the terms discussed and implied.

Signature:_____________________________________ **Initials:**______ **Date:**______________