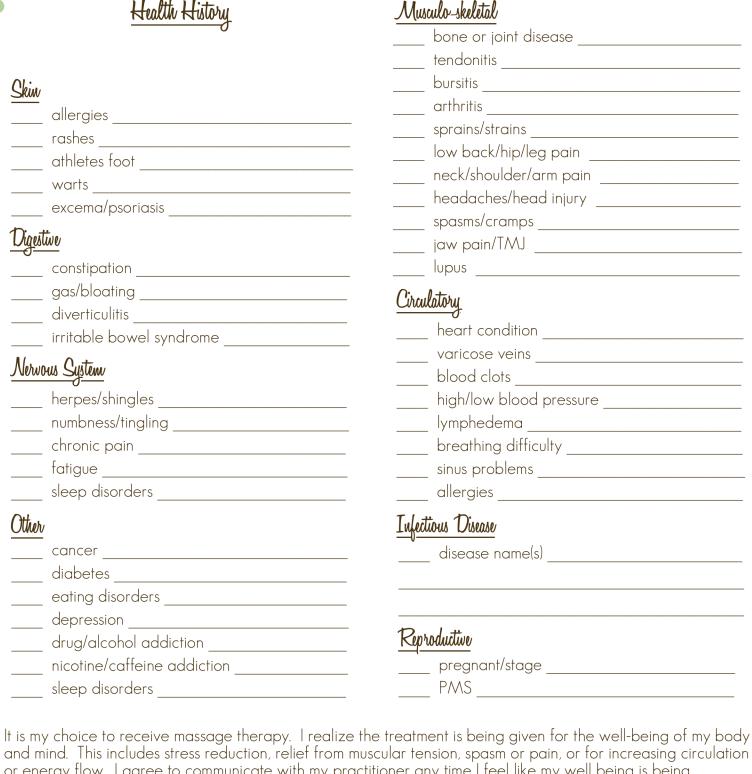


Nourish Massage Bodywork & Skin Therapies Massage Therapy Health History

coulact Information:				
Name:		Date	:	
Email:	Phone	Phone:		
lassage History/Treat	ment Information:			
Have you ever received a professional massage before?			yes	no
What results would	d you like from your m	assage sessions?		
Please prioritize	the areas of your bod	y that you would prefer to be	e massaged.	
Please check the	areas of your body th	at you give permission to rece	eive massage:	
☐ Scalp	☐ Face	☐ Décolleté/Chest	Arms	☐ Back
Abdomen	Legs	☐ Feet	☐ Glutes	☐ Neck
Are you currently s	seeing a medical prac	titioner? Please explain if ye	s. yes	_ no
List exercise & stre	ess reduction activities	including frequency.		
List all medication	s/supplements that you	u are currently on including Ty	ylenol, aspirin, ibuţ	orofen, etc.
Please list any sur	geries/accidents inclu	ding year and treatment(s) re	ceived.	



and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Signature	Date:
9 4 4 4	