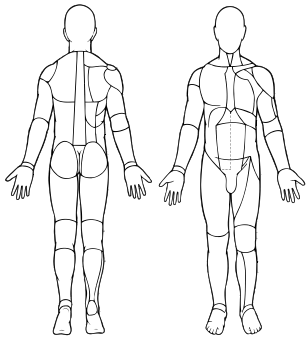
12th Avenue Massage Therapy Group

2100 North 12th Avenue Pensacola, Florida 32503
Telephone: 850-432-6870 Fax: 850-432-6815
Establishment License #MM009764

Client/Patient Health Information Form

Name (First)_____ (MI)_____ (Last)_____
City_____ State_____ Zip_____
Telephone (Home)_____ (Cell)_____use to contact? home#☐ cell#☐
Date of Birth_____ Male___ Female ___
What is your primary reason for massage? _____
Who referred you? I would like to thank them._____



Please shade in the areas above that are causing you discomfort and /or pain.

Please check any condition(s) and/or symptom(s) that you have:

☐ Abdominal pain	☐ Digestive disorders	☐ Low blood pressure
☐ Allergies	☐ Dizziness	☐ Migraine headache
☐ Arthritis	☐ Depression	☐ Muscular injuries
☐ Blood clots	☐ Fatigue	☐ Respiratory disorder
☐ Carpal tunnel	☐ Heart disease	☐ Sinusitis
☐ Chest pain	☐ High blood pressure	☐ Skeletal injuries
☐ Circulatory disorder	☐ Insomnia	☐ Skin disorder
☐ Contagious disease	☐ Joint disorder	☐ Spinal disorder
☐ Constipation	☐ Kidney disorder	☐ Varicose veins
☐ Diabetes	☐ Liver disease	☐ Other

Use this space to describe any of the above conditions and symptoms and list any additional conditions you may have_____
_____
_____

Are you taking a blood thinner? _____

Physicians Name _____Phone #_____
Are you currently under a doctor's care? Yes ☐ No ☐
If yes, please explain _____
_____
Is there anything else that I should know about you, your health, or your body before administering massage therapy? Please describe _____
_____

- I understand that the massage therapist does not diagnose. The massage therapist does not prescribe medical treatment or medications, nor do they perform spinal manipulations. Massage is not to be used as a substitute for medical examination or diagnosis and it is recommended that I see a physician for any ailments that I might have.
- I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.
- **I understand there is a 12 hour cancellation policy. If 12 hours' notice is not given, I will be charged for the amount of the service.**

Date _____ Signature_____

Email address_____ Would you like to receive our newsletter? □ yes □ no
(we occasionally send emails to let you know about promotions and events at 12th Avenue Massage Therapy Group)

Office use: Therapist Name_____ MA#_____