



1048 W. James Street #104

Kent, WA 98032

(Phone) 253.850.2800 (Fax) 253.850.2805

Name: _____ Date of Birth: ___/___/___ Female Male

Address: _____ City: _____ State: _____ Zip: _____

Phone# home: _____ Work: _____ Cell: _____

Employer: _____ SS#: _____

Emergency Contact: _____ Phone# _____

Referred by: _____ Email: _____

Have you had a massage before? _____ How long since your last session ? _____

Are you currently experiencing any of the following? If yes, please explain.

Pain or Tenderness: Yes No _____

Numbness or Tingling Yes No _____

Stiffness Yes No _____

Inflammation Yes No _____

Are you currently seeing a medical doctor? Yes No If yes please explain and provide Dr. Name and phone number.

List any illnesses, injuries, surgeries or health concerns you have now or have had in the past three years.

List all current medication and pain relievers you have taken recently. _____

Please list any additional information you would like your therapist to know about your physical or emotional health. _____

I understand massage practitioners do not diagnose or treat illness, disease, or other physical or mental disorders. It has been made clear to me that massage is not a substitute for a medical examination or diagnosis and that I should see a physician for any medical questions and concerns I may have. I have stated all known medical conditions and take it upon myself to keep the practitioner updated on any changes in my health.

Signature: _____ Date: _____