Simply Relax
Therapeutic Massage

www.simplyrelaxnd.com
1207 Prairie Parkway
West Fargo, ND 58078
701-356-8100

HEALTH HISTORY INFORMATION

OFFICE USE ONLY

Date: __/___/__ ppd/gc_____

Name_____ Date of birth:____/____/____

Address _____ _____

City _____ State _____ Zip _____

E-Mail_____@_____

(appt reminder, weekly openings/promotions)

Home Phone_____Cell/Work:_____Cellular Provider:_____

Occupation/Employer_____

Emergency Contact_____ Phone_____

Physician_____

Chiropractor_____

How did you hear about us?_____

Are you currently under any medical supervision? If so, please explain:

_____

Are you currently taking any medication? _____

Please list any major surgeries? _____

Reason for your massage treatment today? _____

Have you received massage therapy before? Yes or No

If yes, how long ago?_____

What type of exercise do you do weekly? _____

Please circle any symptoms presently or recently experienced:

Acne	Heart Disease
AIDs (HIV)	High Blood Pressure
Allergies	Hives/Shingles
Arthritis	Joint Problems
Athlete's Foot	Kidney Disease
Back Pain/Tension	Lung Disease
Cancer/Tumor	Multiple Sclerosis/Parkinson's Disease
Constipation	Psoriasis
Depression/Anxiety	Sprain/Strain or Dislocation of a joint/muscle
Diabetes	Stroke
Eczema	Sensitivity to lotions, Oils or scented oils
Fibromyalgia	Thyroid Disease
Headaches	Varicose Veins
	Current weight above 350 lbs

Other _____

Pregnancy

Term: 1 2 3

How many weeks?_____

Do you have any of the following:

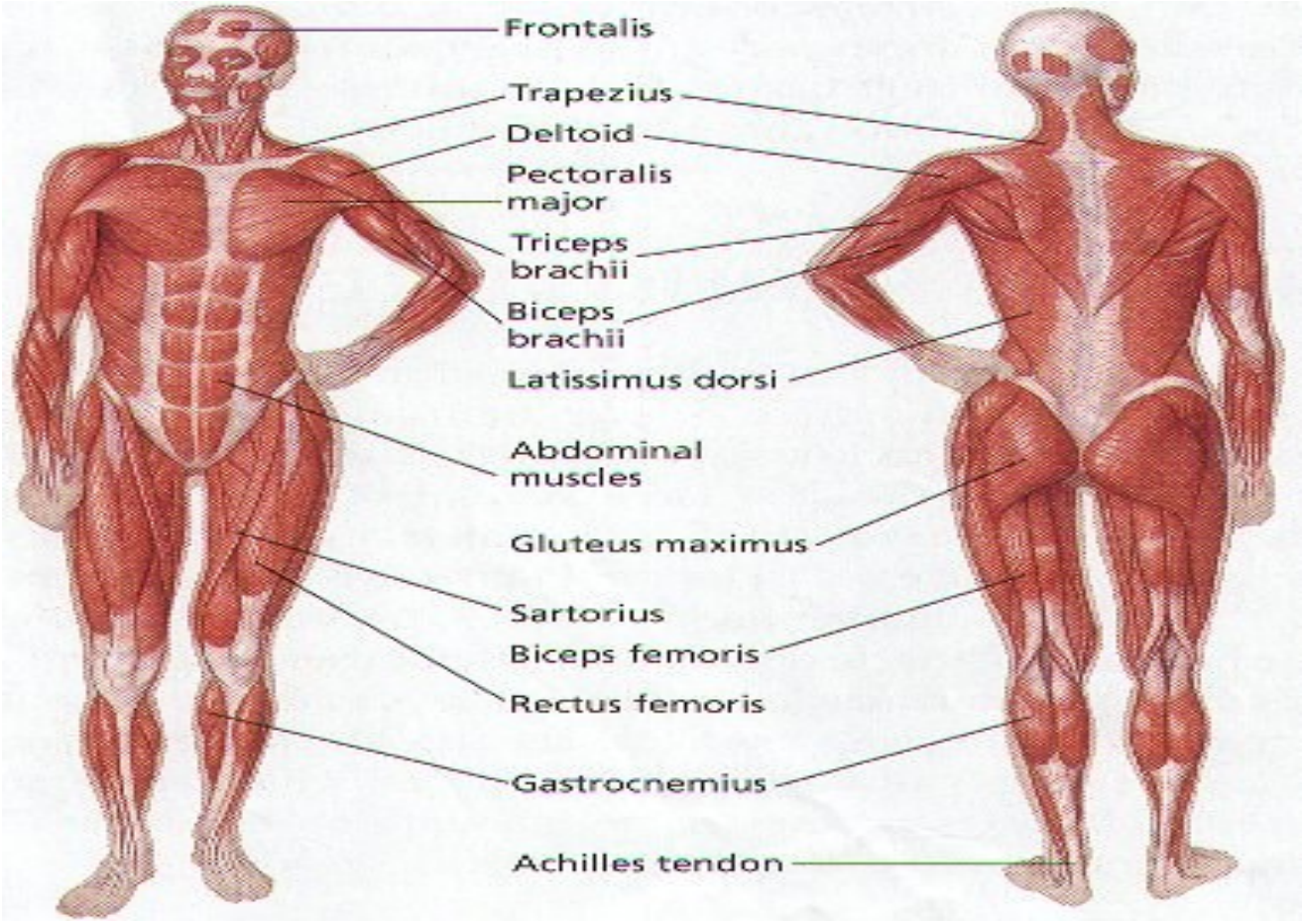
___ Physicians Approval

___ Preeclampsia/Toxemia

___ Premature Labor Symptoms

TURN OVER →

Please circle on the body areas of tenderness or discomfort.



FRONT BACK

Simply Relax Therapeutic Massage provides massage therapy services and treatment for the Restoration, Rejuvenation and Relaxation of the Mind, Body and Health of each client. The purpose of the therapeutic massage is for relaxation and or muscular tension. During the session if you experience any pain or discomfort , *please* let the therapist know.

If any health or medical changes take place, please inform the therapist of these changes as this may affect the type of therapeutic massage you should receive. This is the responsibility of the client and the practitioner will not be liable, should you fail to do so.

CANCELLATION POLICY: Your appointment is a reserved time specifically for you. We ask, that if you need to cancel your massage appointment please notify us at least 8 hours in advance. *Any no-shows, or missed appointments will result in billing the client at $35 missed appointment fee.* We thank you for your consideration in this matter as this will allow us to re-book the appointment.

Signature _____ Date_____

Updated april 2014