LORI NOEL, MASSAGE THERAPIST
174 DEAN STREET
TAUNTON, MA 02780
508-207-8027

PERSONAL HEALTH INFORMATION

Name:_____ Date: _____Referred By: _____

Street Address _____ City, State, Zip _____

Home Phone: _____ Other (cell) Phone: _____

Birthday: _____ Occupation: _____Employer: _____

Email Address: _____

Primary Doctor: _____ Primary Dr. Phone: _____

Permission to consult with primary doctor? _____ Please initial if yes _____

Emergency Contact:_____ Phone: _____

MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? _____ If yes, how often? _____

Date of last massage? _____

What results do you want from your treatment session? _____

Prioritize areas that you prefer to be treated _____

Are there any areas of your body that you do not want massaged? _____

Are you currently under a doctor's care other than for regular well-visits? _____ If yes, please explain: _____

List stress reduction and exercise activities: _____

_____

List current medications, including aspirin, ibuprofen: _____

_____

PREVIOUS MEDICAL HISTORY:

Surgeries: _____

_____

Accidents: _____

_____

Please check any of the following conditions you currently have or have previously had:

_____ bone or joint disease
_____ tendonitis
_____ broken/fractured bones
_____ arthritis
_____ sprains/strains
_____ headaches/head injuries
_____ heart condition
_____ varicose veins
_____ blood clots
_____ high blood pressure
_____ low blood pressure
_____ allergies

_____ rashes
_____ athletes foot
_____ herpes/shingles
_____ chronic pain
_____ cancer/tumors
_____ diabetes
_____ depression
_____ drug/alcohol addiction
_____ nicotine/caffeine addiction
_____ infectious diseases. Please list _____
_____
_____ Are you pregnant? _____
_____Other conditions not listed?_____
_____

24 HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. Otherwise, a $45 cancellation fee will be charged if we cannot fill your spot

Please read the following and sign to state that you agree and understand this statement.

It is my choice to receive treatment. I realize that the treatment is being given for the well-being of my body 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 practitioner of any changes in my health status.

SIGNATURE _____ DATE:_____