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Edmonds, WA 98020
(P) 206-850-8281
(F) 425-776-4300

QUIETUDE

Quietude Massage Therapy Confidential Health Information Form

NAME: _____ BIRTHDATE: _____
ADDRESS: _____ CITY: _____ ZIP: _____
PHONE: _____ WORK/CELL: _____ EMAIL: _____
WOULD YOU LIKE TO RECEIVE E-MAIL FROM US? YES NO
OCCUPATION/EMPLOYER: _____
EMERGENCY CONTACT & PHONE: _____

Please answer the following questions by circling YES or NO and provide any necessary information.

YES **NO** Have you ever had a professional massage?
YES **NO** Do you exercise regularly or participate in any sports? What kind and how often?

YES **NO** Are you currently under the care of any health care provider for a specific condition?
Please explain. _____

YES **NO** Do you take any vitamins, minerals, or medication (including aspirin or ibuprofen)?
Please list medication, dosage, and condition _____

YES **NO** Do you have skin problems or allergies? Please describe _____
YES **NO** Have you ever had surgery? Please list date(s) and procedure(s) _____

YES **NO** Do you have or have you ever had cancer? What type and when? _____

YES **NO** Do you have or have you ever had heart problems? Please explain _____

YES **NO** Do you have high or low blood pressure? Please circle one.
YES **NO** Do you have varicose veins, blood clots or any other circulatory conditions not mentioned?
Please describe _____
YES **NO** Do you have Diabetes? How is it controlled? _____
YES **NO** Do you have arthritis? Osteoarthritis or Rheumatoid? (please circle one) Where is it located?

YES **NO** Do you have bone or joint problems? Please describe _____
YES **NO** Do you experience prolonged episodes of depression or other emotions?
YES **NO** Do you have any infectious or contagious diseases? Please explain _____

YES **NO** Are you experiencing any sleep disorders or change in normal sleeping patterns?
Please explain
YES **NO** Are you Pregnant? What stage? _____
YES **NO** Do you wear contacts, dentures or hearing aid? (please circle one)
YES **NO** Do you have any other medical conditions your therapist should be aware of before you
receive massage _____
YES **NO** Do you have any needs that require special attention? Please explain. _____

Please read carefully and sign/date

I understand that massage therapists do not diagnose illness, disease, or any other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examinations or diagnosis and that it is recommended that I see a physician for any ailments I may have. I have stated all my known medical conditions and I am responsible for informing my massage therapist of any changes in my physical or mental health. I indemnify and hold harmless Quietude Massage, i.e. Swearingen Inc. from any loss or liability arising from services provided by my massage therapist.

Signature _____ **Date** _____