Health Information

Adrienne Lind, NCTMB, BA
ELEVATED massage + bodywork

Name _____ DOB _____ ☐ Male ☐ Female

Address _____ City _____ State ____ Zip _____

Email _____ Phone _____

Occupation _____ Referred by _____

In case of emergency _____ Phone _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever had a professional massage? ☐ Yes ☐ No How recently? _____

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

What are your goals/ expected outcomes for your massage or body work session? _____

Please indicate conditions that you have or have had in the past. Explain more if necessary in fields below.

Stress, anxiety or depression	☐ Yes ☐ No	Osteoporosis, degenerative spine/disk	☐ Yes ☐ No
Headaches or migraines	☐ Yes ☐ No	Allergies _____	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Bruise easily	☐ Yes ☐ No
Currently pregnant	☐ Yes ☐ No	Broken bones in the past 2 years	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Any injuries in the past 2 years	☐ Yes ☐ No
High or low blood pressure	☐ Yes ☐ No	Cardiac or circulatory problems	☐ Yes ☐ No
Seizure disorder or epilepsy	☐ Yes ☐ No	Back pain	☐ Yes ☐ No
Joint swelling	☐ Yes ☐ No	Numbness or stabbing pains	☐ Yes ☐ No
Varicose veins	☐ Yes ☐ No	Sensitive to touch or pressure	☐ Yes ☐ No
Contagious disease	☐ Yes ☐ No	Muscular or joint pain	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Muscular or joint stiffness	☐ Yes ☐ No
Edema	☐ Yes ☐ No	Dizziness or ringing ears	☐ Yes ☐ No
Autoimmune disorder	☐ Yes ☐ No	Neurological condition	☐ Yes ☐ No

Comments: _____

Is the pain you are in due to an injury? If so, explain: _____
Have you ever had surgery? If so, please explain: _____
Please list any medications you are taking: _____

Signature_____ Date_____