SHEILA PANEGASSER LMT

CONFIDENTIAL CLIENT HISTORY

NAME_____ DATE OF BIRTH_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE (HOME)_____(CELL)_____(WORK)_____

OCCUPATION_____ REFERRED BY_____

HAVE YOU EVER RECEIVED MASSAGE THERAPY?_____

MEDICAL HISTORY

_____HYPERTENSION	_____PREGNANCY	_____MENTAL ILLNESS
_____HEART DISEASE	_____EASY BRUISING	_____OSTEOPOROSIS
_____VARICOSE VEINS	_____SKIN RASH	_____OSTEOARTHRITIS
_____EPILEPSY	_____OPEN SORES	_____RHEUMATOID ARTHRITIS
_____HEADACHES	_____ALLERGIES	_____HERNIATED DISC
_____CANCER	_____HEPATITIS	_____RECENT FRACTURES
_____ARTIFICIAL JOINT	_____RECENT SURGERY	_____DEEP VEIN THROMBOSIS/CLOTS
_____SCOLIOSIS	_____HEART CONDITIONS	_____FIBROMYALGIA

EXPLAIN ANY OF ABOVE AREAS CHECKED:_____

_____

_____

IS THERE ANYTHING ELSE ABOUT YOUR HEALTH HISTORY YOU THINK THAT WOULD BE USEFUL FOR YOUR MASSAGE PRACTITIONER TO KNOW TO PLAN A SAFE AND EFFECTIVE MASSAGE FOR YOU?_____

LIST ANY CURRENT MEDICATIONS, VITAMINS OR HERBS_____

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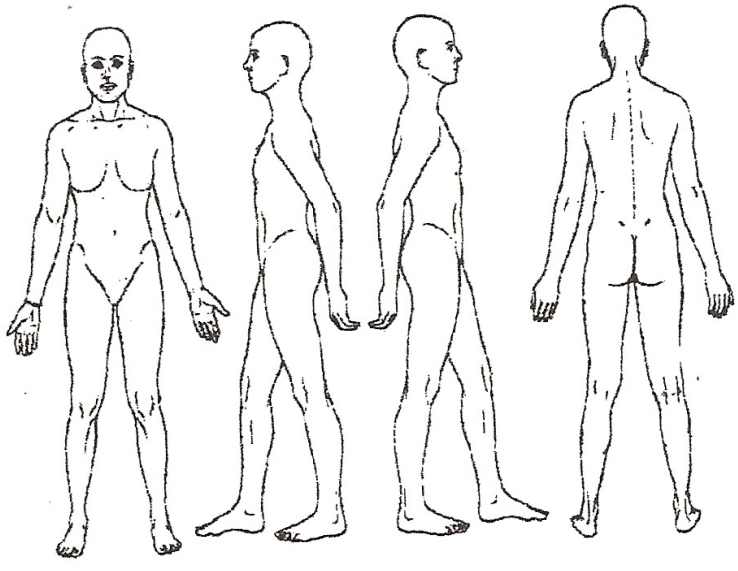

PLEASE CIRCLE AREAS WHERE YOU ARE EXPERIENCING PAIN, NUMBNESS, OR DISCOMFORT

PRESENT SYMPTOMS_____

IS THIS CONDITION INTERFERING WITH WORK_____ SLEEP_____ DAILY ROUTINE_____