

SERENE MASSAGE & WELLNESS HEALTH FORM

NAME: _____

ADDRESS: _____

DOB: _____

PHONE: _____

Email: _____

How did you hear about Serene Massage & Wellness?

1. When was your last professional massage? _____

2. Please list any surgeries you have had: _____

3. Please list any accidents you have had: _____

4. Please list any health challenges you currently have: _____

5. Please list any allergies you have: _____

6. Please list any medications you currently take: _____

7. Please list all areas of tension or pain: _____

8. Please list all vitamins or health supplements you currently take: _____

9. How much water do you drink per day? _____

10. How much caffeine do you drink daily? _____

11. Is there anything else I should know about you? _____

I have stated all conditions that I am aware of and that this information is true and accurate to the best of my knowledge. I agree to inform my massage therapist immediately of any change in conditions as stated above. I acknowledge that this information is confidential. Serene Massage & Wellness is not held liable for the management or arising of conditions.

Signature: _____ Date: _____