TRIMESTERS MASSAGE HEALTH HISTORY

DATE:

NAME:

ADDRESS: POSTAL CODE:

PHONE NUMBER - Day: Evening:

EMAIL:

REFERRED BY:

Have you ever received massage in the past? Yes / no

Frequency of treatment:

Date of last treatment:

Current reason for seeking treatment:

Please list any medications or herbal remedies you are taking:

Please list any medical conditions, both current & past (ie) heart disease, asthma, high blood pressure, cancer, etc ... :

Have you ever been in a motor vehicle accident? Yes / no

Please give date(s) & treatment received: