Elizabeth Zebold, LMP
(360) 319-8941
PO Box 173, Bow WA 98232

Health Information

Name: ___________________________Phone: ______________ Date of Birth:__________
Address:___________________________________City:___________State: ___Zip:_______
Emergency Contact: ______________________________________ Phone:______________

Primary Health Care Provider: ___________________________ Phone:______________
I give my massage therapist permission to consult with my health care provider regarding my health and treatment if necessary. Initials:_____ Date:____________

Please consider any previous and current health concerns. The information you provide will help ensure your safety and comfort.

Rate your level of stress: Typically relaxed 1——————————— 10 Continuously overwhelmed

Yes No Do you have diabetes?
Yes No Are you pregnant? If yes, due date:____________________
Yes No Do you have arthritis?
Yes No Do you have high blood pressure? If yes, is it controlled? ___________________
Yes No Do you have varicose veins?
Yes No Do you have any contagious illness?
Yes No Do you have circulatory problems?
Yes No Do you have numbness or stabbing pain anywhere? ___________________________
Yes No Do you have any particularly sensitive or painful areas that I should be mindful of?
____

Please list any significant accidents or injuries:_______________________________________
____
____

Do you have any other medical conditions or health concerns that might affect your massage?
____
____

Please list your daily activities (work, exercise, home):__________________________________
____

Please Note:
I request at least 24 hours notice for cancellation of an appointment unless it is due to an emergency. If you miss an appointment without timely notification, I still will request payment for my time.

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I have provided all of my known medical information and I agree to inform my practitioner of any changes in my health. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. If I experience pain or feel that my well-being is compromised during the session, I promise to inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I give my consent to receive treatment.

Signature:____________________ Date: _____________