Touch Of Tranquility

MASSAGE

www.touchoftranquilitymassageaz.com

Medical History

Please indicate any exisiting or recent conditions:

___ AIDS/HIV+
__ Allergies (list below)
___Asthma
__ Back problems
__ Blood disorders
__ Broken bones/pins
__ Cancer
__ Carpal Tunnel
__ Diabetes
__ Disc problems (list below)
___Fibromyalgia
___Headaches/Migraines
___Heart Problems
__ High blood pressure
__ Insomnia
__ Low blood pressure
__ Muscle spasms/cramps
__ Neck Problems
__ Numbness
__ Osteoarthritis
__ Pregnant (list below)
__ Rheumatoid arthritis
__ Skin conditions
___Sprains/strains
__ Spinal problems
__ Strokes
__ Surgeries
__ TMJ/jaw pain
__Other

Please explain every checked condition:_______________________________________
____
____

Please list current medications:____
____
____

Have you ever received massage therapy? ___Yes __No
If yes, when was your last massage? ____________________________
Desired pressure: ___ Light ___ Firm ___ Deep
Were you referred by someone? __Yes __ No
If yes, by whom? ______________________

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