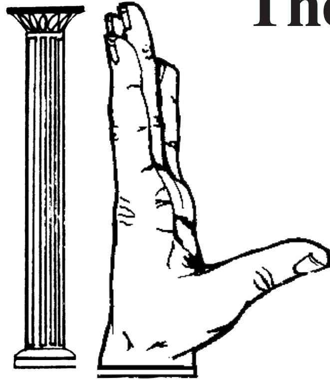

The Massage Guy ™

Eric Katz

WA License # MA07381

1605 12th Avenue
Suite # 9
Seattle, WA 98122
PH: (206) 427-2192

Massage Therapist/Client Health Records ©

ALL RECORDS CONFIDENTIAL

DATE ____________________

NAME ___________________________ ADDRESS ___________________________________

PHONE _________________ DATE OF BIRTH______________ OCCUPATION___________

Referred by: paper______________ Friend (who) ________________ Other _______________

In case of emergency contact: (name) _____________________________ Ph: _______________

REASONS FOR MASSAGE (Indicate all that apply)

Personal Growth _________ Stress _________ Injury/pain ________ Other _________

Physical Discomfort/Injuries in recent six months: _______________________________________

Medications: ____

If you currently have, or within the last year have had, any of the following, please indicate and give details below. ***A "YES" ANWER WILL NOT NECESSARILY PRECLUDE YOU FROM RECEIVING A THERAPEUTIC MASSAGE***

Y ___	**N ___**	**VARICOSE VEINS**	**Y ___**	**N ____**	**HERPES**
Y ___	**N ___**	**AIDS/HIV**	**Y ___**	**N ___**	**FRACTURES**
Y ___	**N ___**	**HEMATOMA**	**Y ___**	**N ___**	**CANCER**
Y ___	**N ___**	**ECZEMA**	**Y ___**	**N ___**	**RASHES**
Y ___	**N ___**	**INSOMNIA**	**Y ___**	**N ___**	**HEART PROBLEMS**
Y ___	**N ___**	**WHIPLASH**	**Y ___**	**N ___**	**HIGH BLOOD PRESSURE**
Y ___	**N ___**	**HEADACHES**	**Y ___**	**N ___**	**LOW BLOOD PRESSURE**
Y ___	**N ___**	**CONSTIPATION**	**Y ___**	**N ___**	**CONTAGIOUS DISEASE**

Y ___ N ___ OTHER ______________________________

12 HOUR CANCELLATION IS REQUIRED OR 50% OF THE SESSION WILL BE CHARGED.

CLIENT'S SIGNATURE ____