Indian Head Massage Health History

Name____
Address____
City/Prov.________________________________Postal Code______________
Home Tel: _______________________Bus. Tel.:________________________
Email:____
Occupation______________________Referredby________________________
Doctor______________________Dr.Tel:____________Date of Birth __________
Reason for treatment today?
____

Do you suffer from or have you every suffered from any of the following:
Indicate **C** (current) or **P** (past):

Thrombosis/blood clots ____
Recent surgery ____
Neck or head injury ____
Epilepsy/seizures ____
Diabetes ____
Skin disorder or infection ____
Pregnancy ____
Allergies ____

High or low blood pressure ____
Describe ___________________________
Describe ___________________________
Any dysfunction of nervous system ____
Recent hemorrhage ____
Scalp condition or infection ____
Dizziness or fainting spells ____
Sensitivity to fragrance ____

Comments:____
____
____

Are you currently under the care of a health care professional for a specific condition?____
____

Are you currently taking any medication or supplements? If so, please list:
____
____

I declare that the information I have given is correct and as far as I am aware I can undertake treatment without any adverse effect.
I have been fully informed about the session and the possible effects and fully understand the explanation and have no further questions at this time.
I give my permission voluntarily for Indian Head Massage.

Client Signature ____________________________Today's Date__________