ALIFE MASSAGE CASE HISTORY

Full Name: …….. Phone: …… DOB: ……

Occupation: …….. Email: …… Emergency contact: …….

Do you have any injuries & or Complaints ? Yes / No If yes, …….

Have you had any operations or major dental work ? Yes / No If yes, ……

Do you or have you ever suffered from any of the following conditions: (please circle)

Asthma Epilepsy Stroke Heart Attack Osteoporosis Varicose veins

Cancer Migraine High/Low blood pressure Diabetes Deep Vein thrombosis

Do you take recreational and or pharmaceutical medication ? Yes / No ……

Regular Bowel movements? Yes / No Are you Pregnant? Yes / No / N/A
Is your menstrual cycle regular? Yes / No / N/A

Skin Type:……. Dry……..Oily……..Sensitive……..Normal…… Combination

Do you have any allergies? Are you allergic to any essential oils? Yes / No …….

Do you smoke? Yes / No Amount?..... Do you drink tea/coffee? Yes / No , per day?.....

Do you drink Alcohol? Yes / No Amount?.....

How many hours per week do you spend taking time out for yourself?.....

Do you do regular exercise? Yes / No Activity & how often?.....

Do you suffer from any of the following: (please circle) Fatigue Stress Anxiety

Phobias Depression Postnatal depression Nervousness Anger Menopause

Addiction Mood swings Insomnia Anorexia Rage

Do you have any other conditions that we should know about?.....

What is your main concern to have a Massage?.....

I, the undersigned hereby state that all the above information is true and correct to the best of my knowledge: No liability: we have no liability to you or any other person for-

Health complaint(s) or injury incurred, by the undersigned , as a result of massage received whilst on these premises.

Health complaint(s) or injury incurred , for what ever reason, by the undersigned during the period of attendance on these premises.

SIGNATURE…… DATE…….

BROOKE, ALIFE MASSAGE