Graceful Touch Massage
20148 Cortez Blvd Brooksville, FL 34601
(352) 610 - 1842
Establishment License # MM29738 LMT# MA45725

New Patient Medical History Form

Last Name _____ First Name _____ DATE _____

Address _____ City, State_____ ZIP _____

Email Address _____ Phone _____

Birth Date _____ Occupation _____ Height _____ Weigh _____

Primary Care Physician _____ Date of Last Visit _____

How did you hear about me? Please be specific. _____

Circle all that apply

High Blood Pressure	Diabetes	Heart Disease
Low Blood Pressure	Dizzy Spells	Herniated Disk
Skin Allergies	Auto Immune Disorder	Stroke

Any Condition Not Listed _____

Are you taking any Medications? If so, what? _____

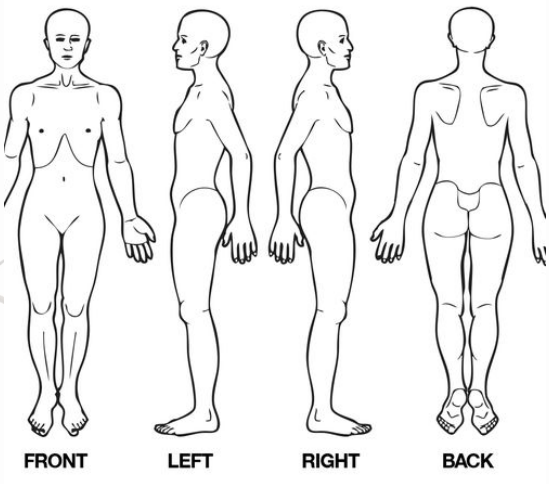
Pain History

Are you Experiencing any pain in your joints or muscles? YES or NO *Where?* _____

Describe the Pain (aching, sharp, shooting, pulsing, burning, etc.) _____

Does it affect your job or activity daily? YES or NO

Using the diagrams to the right shade the areas that need specific attention or are areas of discomfort.



Massage Therapist Release Statement

I, _____, the undersigned do hereby declare the statements contained in this document are true and complete to the best of my knowledge. By signing this health form, I state that I'm willing to receive Massage Therapy and know of no contra-indications in my present condition, and will not hold Graceful Touch Massage or the massage therapist responsible for my treatment.

Signature _____

Print Name _____