Essence of Bliss Massage • 541-343-3455
Sarananda Davis, LMT Lic. # 7612

Personal Health Form

All the information you provide will be kept confidential.

Name:_____ Date:_____ DOB:_____

Address:_____ Zip:_____

Phone: (home)_____ (cell)_____ (wk, if okay to call you there)_____

Email:_____ Add me to mailing list:_____

Emergency Contact: (name)_____ (phone)_____

Occupation:_____ How did you hear about us?_____

Insurance Company(if applicable):_____ Member#_____

Insurance Phone# (or Provdier#):_____ Please hand card to front desk to copy.

Please check what applies to you:

Cancer_____	Back problems_____	HIV/Aids_____
Arthritis_____	Dislocated joints_____	High/low blood pressure_____
Kidney disease_____	Surgeries_____	Heart problems_____
Diabetes_____	Allergies_____	Communicable diseases_____
Seizures_____	Asthma_____	Varicose veins_____
Fractures_____	Skin disease_____	Depression_____
Torn cartilage_____	Blood clots_____	Others (list)_____

_____

Yes or no, please indicate:

_____ wearing contact lenses? _____ pregnant? If yes, how far along?_____

_____ currently have a contagious disease? If so, please explain_____

_____ currently taking medication? For what condition(s)?_____

Have you had previous massage?_____

What would you like to achieve from this session today?_____

Are there any areas of your body that you prefer not to be massaged? If so, what areas?_____

_____

Are you currently in pain or discomfort?_____

If so, where?_____

Where in your body do you store tension?_____

I certify that the above information is true and correct to the best of my knowledge. I specifically relieve my massage therapist from all liability for damages or injury to me which result from my failure to report any relevant information about my health and condition to my therapist. I also acknowledge that 24 hours notice is required to cancel a scheduled appointment and if I fail to cancel within this time frame I will be charged and responsible to pay for ½ the fee of a regular session.

Signature:_____