# Spa and Massage Health Form

Prior to receiving treatment, we require an accurate health history to assist us in treating you safely. If your health status changes in the future please inform the treatment provider.

Last Name: _____ First Name: _____

Address: _____

Best Number to reach you at: _____ W _____

Gender M___F___ Date of Birth: M___D___Y___ Email: _____

How did you hear about us? _____

What do you hope to achieve from your treatment today? _____

Have you had surgery in the past 12 months? N___Y____ If yes please specify:_____

Do you have any allergies? N___ Y____ If yes please specify: _____

Have you had any of these health conditins in the past or present? Please check all that apply.

- ❑HIV
- ❑Anxiety/Mental Health Issue
- ❑Hepatitis
- ❑Warts
- ❑Cancer
- ❑Arthritis
- ❑Diabetes
- ❑Asthma
- ❑TB
- ❑Shortness of Breath
- ❑Heart Condition
- ❑Emphysema
- ❑Chronic Congestive Heart Failure
- ❑Bronchitis
- ❑Thyroid
- ❑Chronic Cough
- ❑Heart Disease
- ❑Phlebitis/Varicose Veins
- ❑Pace Maker of Similar Device
- ❑Chronic Cough
- ❑Heart Disease
- ❑Phlebitis/Varicose Veins
- ❑Pace Maker of Similar Device
- ❑Hysterectomy
- ❑Hypersensitivity
- ❑Eczema
- ❑Stroke
- ❑Psoriasis
- ❑High Blood Pressure
- ❑Skin Conditions
- ❑Low Blood Pressure
- ❑Fungus
- ❑Herpes
- ❑Corns
- ❑Infectious Disease
- ❑Ingrown Toenails
- ❑Epilepsy
- ❑Other