The Way of Touch

Health History

Information obtained will help to address the session according to your current needs. Your personal information is kept strictly confidential.

Full Name:	Date:
Birth Date:	E-Mail:
Home Phone:	Mobile Phone:
Relationship Status:	Occupation:
Kids: Yes _____ No _____	

Have you had any previous experience with massage? Yes _____ No ______

If yes, please explain whether for stress or relief/relaxation or treatment of specific condition

____

____

What do you want to gain from massage and bodywork sessions? ___________________________

____

____

Do you have any questions about massage in general or about this session?____________________

____

____

Have you recently experienced any major emotional, psychological changes, past traumas?

____

____

Where do you hold your tension?____

____

Do you sleep well? ____

____

What role does exercise play in your life? ____

____

Do you drink coffee, smoke cigarettes or have any major addictions? _________________________

____

____

How would you describe your general health? ____

____

____

Are you currently taking any medication? ____

____

____

Are you currently seeing a doctor for any reason? ____

____

____

Have you had any serious operations, traumatic accidents, chronic illness, chronic pain, chronic virus infections?

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Do you have any skin rashes or other problems now? _____________________________________

____

If you experience any discomfort during this session, please let me know so I will adjust to your level of comfort.

ALL THE INFORMATION DISCUSSED DURING TREATMENT WILL REMAIN CONFIDENTIAL.

______________________________ ______________________________

Signature Date

Thank you,

Yifat Donenfeld - BCTMB, LMT
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