Personal I	nformation
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Name:		Date:
DOB/ Age:		
Campus/Current Information		
Phone:	Email:	

## Medical History

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In order to plan a massage session that is safe and effective, I need some general information about your medical history.

Please list current medications, including aspirin, herbs, supplements, etc.:

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•	Never Smoked (amount):		Currently Smoke* *Number of years smoked:_			
If you quit smoking, when did you quit?:						
Do you currently use cigars, pipes, or smokeless tobacco products? Yes No List all surgeries: List all accidents/injuries:						

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