



Massage Registration Form

Personal Information	Today's date: _____			
Name: _____	Date of Birth: _____	Age: _____	SSN: _____	
Address: _____				
City: _____	State: _____	Zip: _____	Home Phone: _____	Cell Phone: _____
Employer: _____	Occupation: _____	Work Phone: _____		
Emergency Contact Person: _____	Relationship: _____	Phone # _____		
Address: _____				
Who is your primary care doctor? _____		Referred to this office by: _____		
Learned about Holistique Medical Center from: _____				
Have you recently been in a car accident? _____		When? _____		
Have you had any serious injury in the past? _____		When? _____		
Have you seen a Professional Massage Therapist in the past? _____				

Insurance Information		
Person responsible for account: _____	Relationship: _____	Insured's DOB: _____
Primary Insurance: _____	Group #: _____	Subscriber #: _____
Secondary Insurance: _____	Group #: _____	Subscriber #: _____

Health Problems – Please list your main health problems, duration, and current treatments
1. _____
2. _____
3. _____
4. _____

Massage- Please list anatomical area you would prefer massage treatment. Eg lower back, neck, arms.
1 _____
2 _____
3 _____
4 _____