BLUEZONEHEALTHNH.COM
P: 603-880-4150
F: 603-880-6765

BLUE ZONE HEALTH

29 RIVERSIDE STREET
UNITS A & B
NASHUA, NH 03062

MISSION: TO RAISE THE VIBRATION OF EVERYONE WHO WALKS THROUGH OUR DOOR.
VISION: TO REVOLUTIOIZE HEALTHCARE IN OUR COMMUNITY.

Welcome to Massage Therapy!

Today's Date:_____

Name:_____ Date of Birth:_____ Age:_____

Any change in your personal information (i.e., address, etc.) from what we have on file?

☐ Yes, there is a change *(please provide this information)* ☐No Change

Have you ever had a professional massage? ☐ Yes ☐ No

What is your preferred pressure? ☐ Light ☐ Medium ☐ Heavy ☐ Unsure

Do you have any allergies? _____

Do you have any skin sensitivities? _____

Have you ever been treated for cancer? ☐ Yes ☐ No

If yes, did that treatment include Radiation, Chemotherapy, or surgery?

Please explain:_____

If yes, did your treatment include the removal, radiation, or testing of any lymph nodes? ☐ Yes ☐ No

If yes, are you at risk of lymphedema? ☐ Yes ☐ No

Do any of the following apply to you?

___Arthritis	___Headaches	___Sciatica	___Torn Ligament
___Bruise easily	___Heart Disease	___Scoliosis	___Varicose veins
___Cancer	___Hypertension	___Tendinitis	___Wear Contacts
___Diabetes	___Osteoporosis	___Torn muscle _____	
___Digestive issues	___Pregnant	___Other _____	

___Skin condition (including warts, open lesions/broken skin, etc)_____

Please explain any of the above checked conditions further _____

_____

What is your primary reason for receiving a massage treatment today? _____

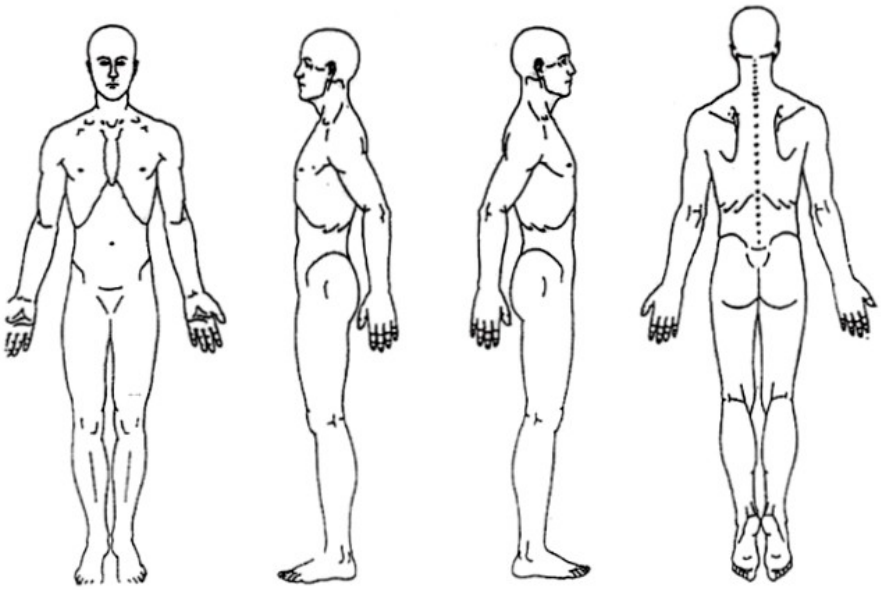
_____

On the flip side, please indicate your areas of pain and discomfort on the diagrams. ⇨

Signature_____

Date_____

Body Scan Evaluation Form



HIPAA Disclosure

In an effort to maintain patient confidentiality and the guidelines within the HIPAA regulations, please fill out this section in regards to having someone other than you obtain information regarding upcoming appointments and/or information from your *massage therapy* records, specifically.

☐ I decline to give permission to a family member/friend.

☐ I give permission to the following family/friend:

Name: _____ Relation: _____ Ph #:_____

Patient Signature:_____ Date:_____