

CONFIDENTIAL INFORMATION

WELCOME!! WE WANT TO MAKE YOUR APPOINTMENT AS PLEASANT AND COMFORTABLE AS POSSIBLE.
IF AT ANY TIME YOU HAVE ANY QUESTIONS REGARDING YOUR VISIT, PLEASE LET US KNOW.

NAME _____ HOME # _____ WORK# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____ M _____ F _____ MARITAL STATUS _____

OCCUPATION _____ REFERRED BY _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY BEFORE? YES NO SOCIAL SECURITY # _____

TYPE OF MASSAGE EXPERIENCED: DEEP TISSUE SWEDISH OTHER _____

ARE YOU TAKING MEDICATION? _____ DESCRIBE _____

EMAIL ADDRESS _____

HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? YES NO

DO YOU HAVE A HISTORY OF THE FOLLOWING?

- | | | |
|--|--|--|
| <input type="checkbox"/> accident | <input type="checkbox"/> sprains | <input type="checkbox"/> breast augmentation |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> seizures | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> whiplash | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> headaches | <input type="checkbox"/> nervous tension | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> disk problems | <input type="checkbox"/> arthritis, bursitis or gout | <input type="checkbox"/> stroke |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> allergies to oils or perfumes | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> wear contacts or other prosthesis | <input type="checkbox"/> cancer |
| <input type="checkbox"/> joint ache | <input type="checkbox"/> surgery | <input type="checkbox"/> colitis |
| <input type="checkbox"/> decreased range of motion | | <input type="checkbox"/> HIV |
| <input type="checkbox"/> broken bones | | |

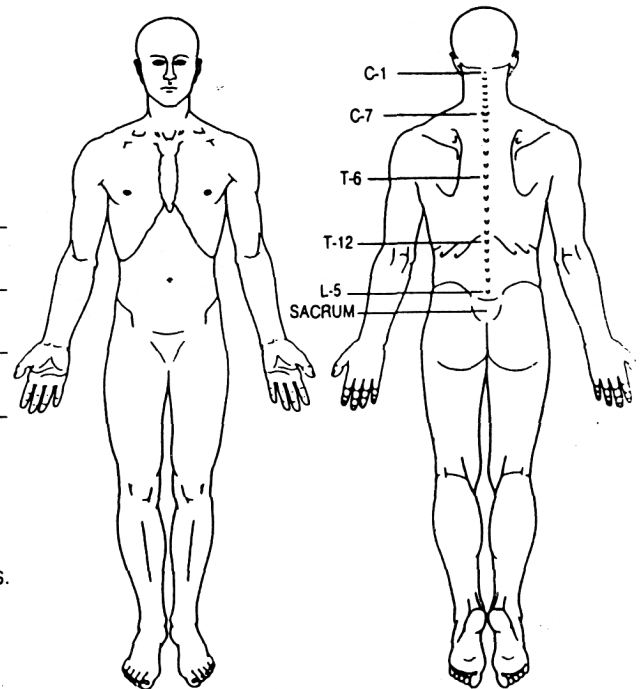
Please indicate if your consumption is:

	None	Light	Moderate	Heavy
salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE ANY OF THE FOLLOWING TODAY:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> sunburn | <input type="checkbox"/> open cuts, bruises, burns |
| <input type="checkbox"/> inflammation | <input type="checkbox"/> irritated skin rash |
| <input type="checkbox"/> severe pain | <input type="checkbox"/> poison ivy |
| <input type="checkbox"/> headache | <input type="checkbox"/> cold/flu |

PLEASE INDICATE THE PLACES YOU ARE FEELING DISCOMFORT



PLEASE READ THE FOLLOWING AND SIGN BELOW:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

DATE: _____ SIGNATURE _____