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 ☐ EMAIL _____

TYPE OF MASSAGE EXPERIENCED: ☐ DEEP TISSUE ☐ SWEDISH ☐ OTHER _____

ARE YOU TAKING MEDICATION? _____ DESCRIBE _____

_____

DO YOU HAVE A HISTORY OF THE FOLLOWING?

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

DO YOU HAVE ANY OF THE FOLLOWING TODAY:

- ☐ sunburn
- ☐ inflammation
- ☐ severe pain
- ☐ headache
- ☐ open cuts, bruises, burns
- ☐ irritated skin rash
- ☐ poison ivy
- ☐ cold/flu

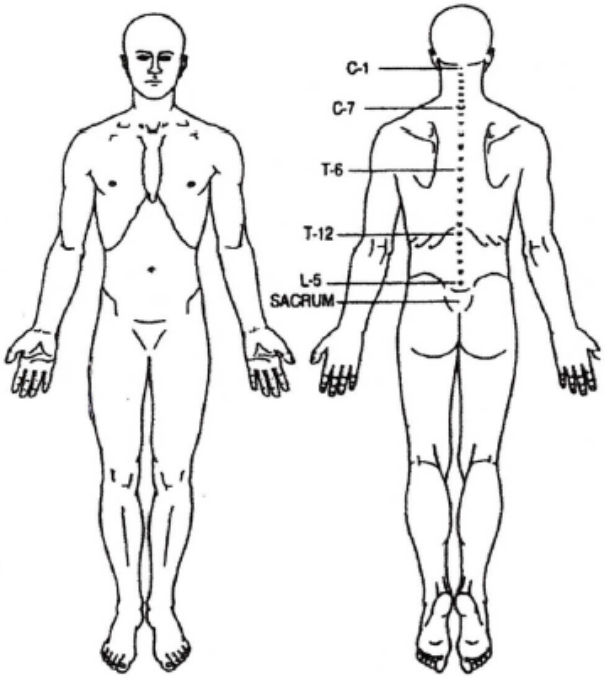
_____

_____

_____

_____

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 _____