

Welcome, we want to make your appointment as pleasant and comfortable as possible.
 If at any time you have questions regarding your therapy session, please let us know.

Name _____ Home # _____ Work # _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ M _____ F _____ Marital Status: S M D W # of Children _____

E-mail Address _____ Occupation _____ Type of Exercise _____

Rate your posture: Excellent Good Fair Poor Have you ever received Massage Therapy? Yes No

Type of massage experienced: Deep Tissue Swedish Other _____

Are you taking Medication? Yes No Describe _____

Are You Pregnant? Yes No How many weeks? _____

Have you consumed alcohol in the past 24 hours? Yes No

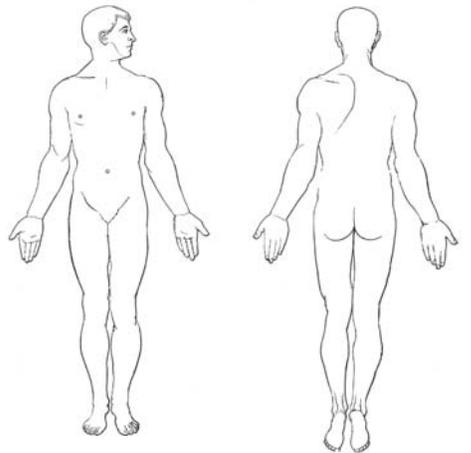
DO YOU NOW OR HAVE YOU HAD ANY OF THE FOLLOWING?

<input type="checkbox"/> accident	<input type="checkbox"/> sprains	<input type="checkbox"/> mastectomy	Please indicate your consumption level:			
<input type="checkbox"/> neck pain	<input type="checkbox"/> seizures	<input type="checkbox"/> breast augmentation	None	Light	Moderate	Heavy
<input type="checkbox"/> whiplash	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> diabetes	<u>salt</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> headaches	<input type="checkbox"/> nervous tension	<input type="checkbox"/> varicose veins	<u>sugar</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> shoulder pain	<input type="checkbox"/> arthritis, bursitis or gout	<input type="checkbox"/> high blood pressure	<u>caffeine</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper back pain	<input type="checkbox"/> allergies to oils or perfumes	<input type="checkbox"/> stroke	<u>tobacco</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> mid back pain	<input type="checkbox"/> wear contacts	<input type="checkbox"/> heart attack	<u>alcohol</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> low back pain	<input type="checkbox"/> scoliosis	<input type="checkbox"/> cancer	<u>exercise</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> joint ache	<input type="checkbox"/> surgery	<input type="checkbox"/> colitis	<u>water</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> decreased range of motion	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> HIV				
<input type="checkbox"/> broken bones	<input type="checkbox"/> carpal tunnel syndrome	<input type="checkbox"/> _____				
<input type="checkbox"/> sciatica						

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 WITH AN (X) THE AREAS YOU ARE FEELING DISCOMFORT



What are your goals/expectations for this therapy session?
 (e.g. relaxation, stress relief, pain management, deep tissue, help!!)

- 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 cancellations of less than 24 hours.

Signature _____ Date _____ Referred By _____