

Welcome! We want to make your appointment as pleasant and comfortable as possible.  
Please let us know if at any time you have questions regarding your visit.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME #: \_\_\_\_\_ WORK #: \_\_\_\_\_ CELL: \_\_\_\_\_ PAGER: \_\_\_\_\_

DOB: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

WOULD YOU LIKE TO BE ADDED TO OUR MAILING LIST?  Regular Mail  
 E-mail \_\_\_\_\_

HAVE YOU EVER RECEIVED MASSAGE THERAPY BEFORE?: \_\_\_\_\_ TYPE?: \_\_\_\_\_

ARE YOU TAKING MEDICATION?: \_\_\_\_\_ DESCRIBE: \_\_\_\_\_

PLEASE CHECK IF YOU HAVE A HISTORY OF THE FOLLOWING:

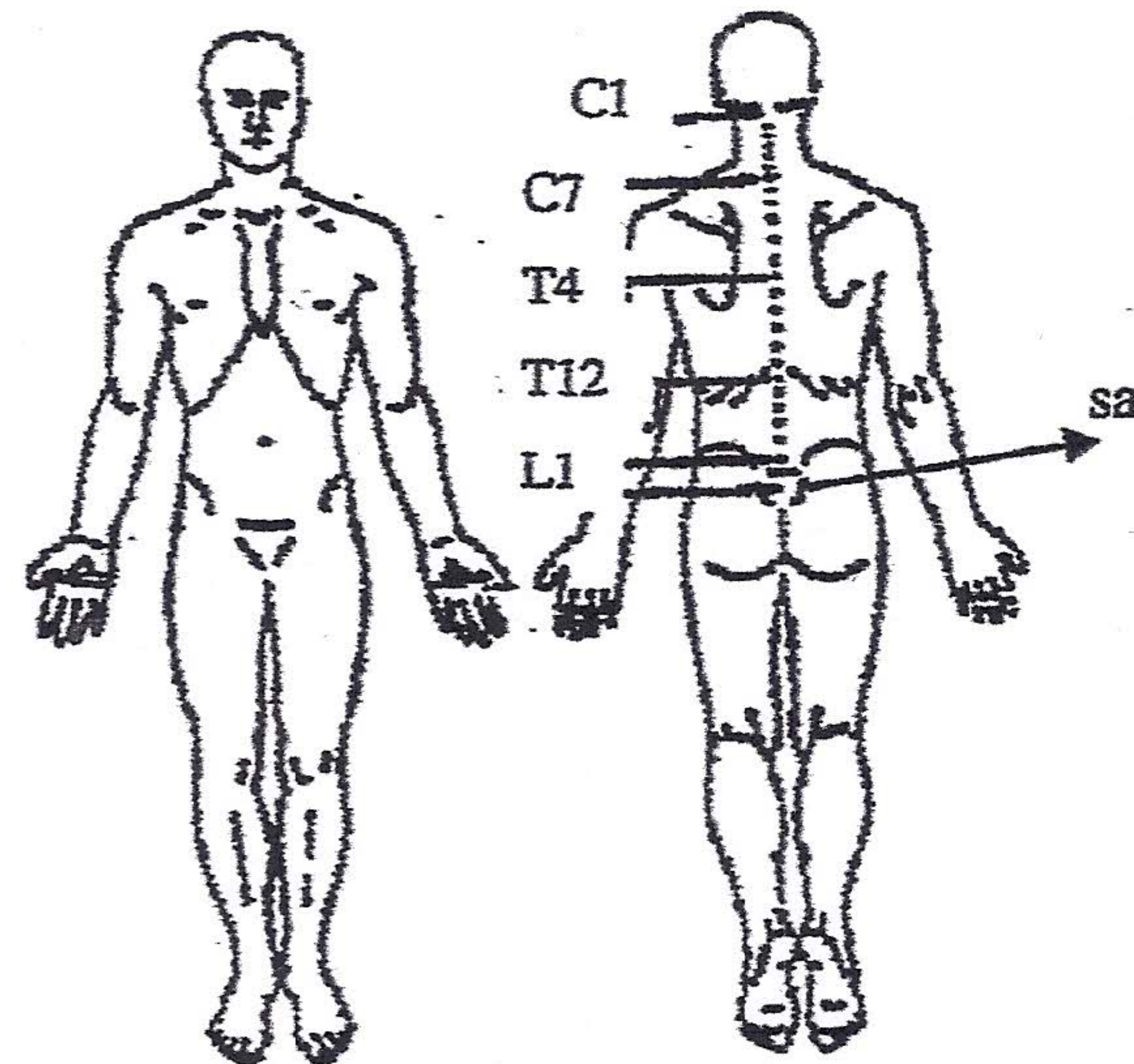
- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Accident       | <input type="checkbox"/> Nervous       | <input type="checkbox"/> High Blood    | <input type="checkbox"/> Surgery        |
| <input type="checkbox"/> Neck Pain      | <input type="checkbox"/> Tension       | <input type="checkbox"/> Pressure      | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Whiplash       | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Scoliosis      |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Bursitis      | <input type="checkbox"/> Syndrome      | <input type="checkbox"/> Stroke         |
| _____                                   | <input type="checkbox"/> Gout          | <input type="checkbox"/> Frozen        | <input type="checkbox"/> Heart Attack   |
| <input type="checkbox"/> Disc Problems  | <input type="checkbox"/> Broken Bones  | <input type="checkbox"/> Shoulder      | <input type="checkbox"/> TMJD           |
| <input type="checkbox"/> Back Pain      | <input type="checkbox"/> Allergies to  | <input type="checkbox"/> Decreased     | <input type="checkbox"/> Fibromyalgia   |
| <input type="checkbox"/> Sprains        | <input type="checkbox"/> oils/perfumes | <input type="checkbox"/> range of      | <input type="checkbox"/> HIV / AIDS     |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> motion        |   |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Sciatica      | <input type="checkbox"/> Seizures      |   |

ARE YOU PREGNANT? \_\_\_\_\_ HOW MANY WEEKS? \_\_\_\_\_

PLEASE SPECIFY ON THE DRAWING THE PLACES YOU ARE FEELING DISCOMFORT TODAY.

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

- |  |   |
|--|---|
| <input type="checkbox"/> Headache                | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Inflammation            | <input type="checkbox"/> Sunburn          |
| <input type="checkbox"/> Fever                   | <input type="checkbox"/> Nausea           |
| <input type="checkbox"/> Skin Rash               | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Open cuts/bruises/burns |   |



PLEASE CHECK 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 understand that I am fully in control of this massage session and can terminate it at any time and for any reason.
- I recognize that the massage therapist is a professional and will treat him/her with respect.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_