CLIENT INFORMATION All information will be kept confidential.

Name:_____ Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

E-mail:_____ Occupation:_____

Date of Birth:_____ Sex: M F Contact Lenses? Yes No # of massages in past?_____ How did you hear about us?_____

Why do you want a massage? _____

Have you ever been in an auto accident? Y/N (Describe if yes): _____

List all medications you currently take: _____

Who is your health care provider/MD? _____Phone:_____

Describe any surgeries, broken bones, major injuries or accidents below – include dates: (use back if necessary): _____

_____

_____

_____

Please check if you have had problems with any of the following

_____ Sinus/allergies	**HIPS, LEGS, FEET**	**ARMS, HANDS**
_____ Numbness/tingling	_____ Leg or foot cramps	_____ Hands cold
_____ Sciatica	_____ Feet feel cold	_____ Loss of grip strength
____ Skin condition/rash	_____ Swollen ankles	_____ Shooting pains
Where_____	_____ Bunions	
_____ Infectious condition	_____ Shooting pains	**LOW BACK**
Where_____	_____ Hip replacement	Pain is worse when:
_____ Area of inflammation	_____ Knee surgery	_____ Lifting
Where_____		_____ Sitting
_____ High/low blood pressure	**SHOULDERS**	_____ Lying down
_____ Osteoporosis	_____Can't raise arm	_____ Bending
_____ Seizures/convulsions	_____ Above shoulder	_____ Coughing
_____ Dizziness/fainting	_____. Over head	_____ Working
_____ Varicose veins		
_____ Bruise easily	**HEAD**	**ABDOMEN**
_____ Heart condition	_____ TMJ	_____ Nausea
_____ Bursitis	_____ Grind teeth	_____ Gas
_____ Arthritis	_____ Splint	_____ Constipation
____ Chest pain	_____ Headaches	_____ Diarrhea
_____ Shortness of breath	Where_____	_____ Tenderness
_____ Diabetes	_____ Head feels heavy	
	_____ Loss of memory	**FEMALES**
NECK	_____ Lights bother eyes	_____ Pregnant
_____ Pain with movement	_____ Ringing in ears	_____# of months
_____ Stiff neck	_____ Loss of balance	_____ Menstrual pain
_____ Grinding/popping	_____ Dizziness	_____ Irregular cycle

Other conditions or information

_____

_____

_____

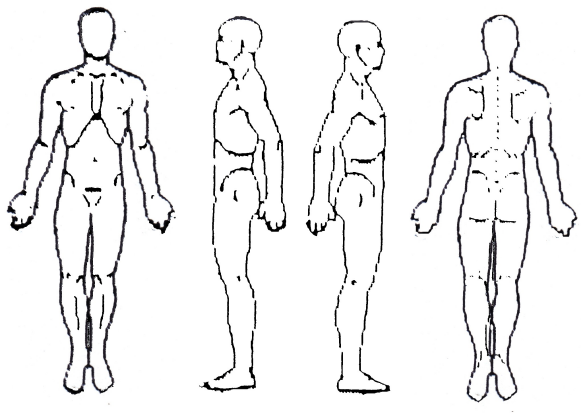
_____

_____

_____

_____

Please circle any areas of pain or injury.



PLEASE READ BACK AND SIGN

PLEASE READ BEFORE SIGNING

I understand that the massage I receive is provided for the basic purposes of relaxation and relief of muscular tension. If I experience any pain or discomfort during my sessions, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my comfort level. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any ailment that I am aware of. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the massage should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have listed all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. If I have a specific medical condition or specific symptoms, massage may be contraindicated and a referral from my doctor may be required prior to service being provided. I understand that this clinic has a 24-hour cancellation policy and I will be liable for full payment for any appointments canceled after this time.

Client Signature:_____ Date:_____