MASSAGE

Name_____ Address:_____
City _____ State _____ Zip _____
Home phone _____ Work Phone _____
Cell phone _____ Date of Birth _____
occupation _____

Referred by: _____

Previous experience with professional massage therapy: _____
_____

Please explain your present complaints and indicate any specific areas where you have pain:
_____
_____

Medical History: Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area. Use the space at the bottom of the page if an explanation is necessary.

_____ Skin condition (acne, rash, allergies, skin cancer, etc.)
_____ Lymphatic Condition (swollen glands, lymphoma, lymph cancer, etc.)
_____ Circulatory condition (heart disease, vericose veins, phlebitis, arrhythmias, etc.)
_____ Neurological condition (sciatica, numbness/tingling of skin, stroke, epilepsy, etc.)
_____ Joint problems (pain/stiffness, arthritis, hypo/hypermobility, etc.)
_____ Bone condition (Osteoporosis, bone cancer, previous fractures, etc.)
_____ Headaches (migraines, cluster, tension, etc.)
_____ Emotional difficulties (depression, anxiety, etc.)
_____ Recent Injuries: Please explain: _____
_____
_____ Previous surgery - type & date :1) _____
2)_____
3)_____
4)_____
_____ Are you taking any medications? Yes____ No ____ if so please list and state what they are for: _____
_____

Your Signature: _____ Date: _____

** Payment is expected at time of visit unless other arrangements have been made **