Name ______________________ Phone ______________________
Address ______________________ E-mail ______________________
City ____________ State ________ Zip ______________________

Have you had a massage before? If so, when? ______________________

Please check off any of the following conditions or symptoms which apply to, giving explanation where needed:

- Sinus/Allergies ____________
- Numbess/Tingling ____________
- Shooting Pains ____________
- High Blood Pressure
- Low Blood Pressure
- Osteoporosis
- Hypoglycemia
- Hyperglycemia
- Diabetes
- Seizures/Convulsion
- Dizziness/Fainting
- Swelling/Edema ____________
- Bruise Easily
- Varicose Vains
- Heart Condition
- Bursitis ____________
- Arthritis ____________
- TMJ/Jaw Pain ____________
- Headaches ____________
- Tendonitis
- Trouble Sleeping
- Constipation
- Diarrhea
- Irregular Menstrual Cycle
- Currently Pregnant

Have you had any recent surgery, serious injury, or traumatic accidents? If so, please specify below

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I understand that the massage therapist that I am given is for the purpose of stress reduction, releif from muscular tension, and improving circulation. I understand that a massage therapist neither diagnoses illness, desease, or any other medical, physical, or mental disorders; nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment I may have.

Client Signature ______________________ Date ____________

Therapist ______________________ Date ____________