

Name _____ Email _____

Address _____ City/State/Zip _____

Phone _____ Birthday _____

Occupation _____ Referred by _____

Would you like to be added to our email list for discounts & specials? _____

In Case of Emergency please contact _____

General and Medical Information

Y N Have you ever had a professional massage? If yes, how often? _____

Y N Are you pregnant? If yes, how far along are you? _____

Y N Are you sensitive to touch/pressure in any area?(ticklish?) _____

Y N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? If yes, please list:

List of current medications and reasons: _____

List of surgeries (type and date): _____

Indicate Areas of Pain/Tension

On a scale from 1-10, 10= highest, rate your levels

Stress _____ Pain _____ Energy _____

How did your symptoms begin and when did they start?

What have you done for relief?

Is the condition getting better/worse?

Please check all that apply

Skin condition- rash, warts, hives, skin cancer, other _____

Lymphatic condition- swollen gland, nasal congestion, lymph edema

Joint problems/stiffness- arthritis, sacroiliac problems, TMJ, other

Bone conditions- osteoporosis, fracture,
other _____

Headaches

Recent injury or accident- whiplash, sprain,
bruise,

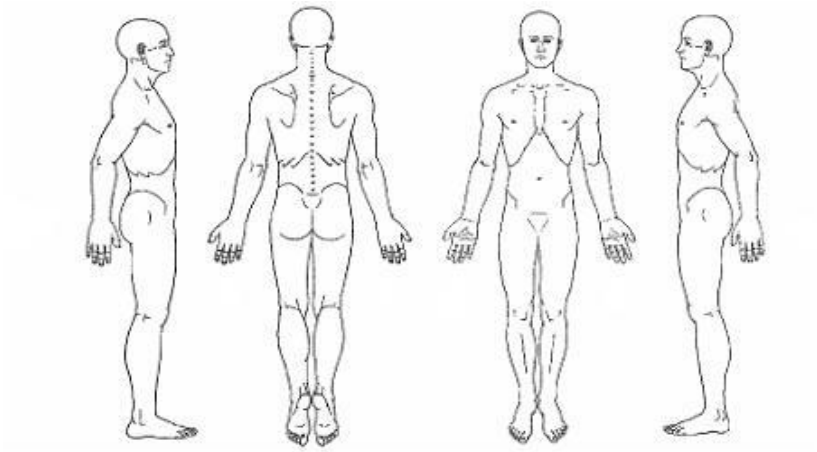
other _____

Circulatory condition- high blood pressure,
varicose veins, blood clots

Numbness/Tingling, Sciatica

Tendonitis, Bursitis

Diabetes



Please mark in the diagram above any areas where you have pain or discomfort.