CONFIDENTIAL INFORMATION

Welcome. I want to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your therapy session, please let me know.

NAME_____**HOME #**_____**WORK#**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

EMAIL_____

DATE OF BIRTH_____**AGE**_____**M**____ **F**____ **MARITAL STATUS**_____

OCCUPATION_____**REFERRED BY**_____

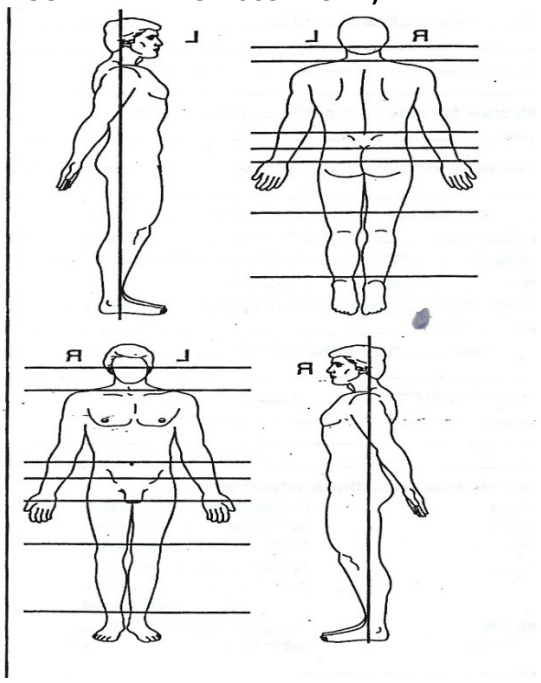
HAVE YOU EVER RECEIVED MASSAGE THERAPY? YES_____ **NO**_____

TYPE OF MASSAGE EXPERENCED _____**DEEP TISSUE** _____**SWEDISH OTHER**_____

ARE YOU TAKING MEDICATION_____**DESCRIBE:**_____

ARE YOU PREGNANT? _____**HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS?YES**___**NO**___

(PLEASE INDICATE BELOW, WITH AN (X), THE AREAS YOU ARE FEELING DISCOMFORT.)



DO YOU HAVE A HISTORY OF THE FOLLOWING:

___accident	___sprains	___mastectomy
___neck pain	___seizures	___breast augmentation
___Whiplash	___abdominal pain	___ diabetes
___headaches	___ nervous tension	___varicose veins
___shoulder pain	___arthritis, bursitis	___high blood pressure
___upper back pain	___ stroke	___allergies to oils/scents
___mid back pain	___wear contacts	___heart attack
___low back pain	___scoliosis	___cancer
___joint ache	___surgery	___colitis
___fibromyalgia	___broken bones	___HIV
___sciatica	___herpes	___hepatitis
___carpal tunnel syndrome	___decreased range of motion	

DO YOU HAVE ANY OF THE FOLLOWING TODAY:

___ sunburn	___ open cuts/bruises/burns	___inflammation
___severe pain	___irritated skin or rash	___poison ivy
___migraine	___cold/flu	

PLEASE READ 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 am responsible for paying for any appointment cancellation of less than 24 hours.

DATE:_____

SIGNATURE:_____

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS THERAPY SESSION?

_____

_____

_____

CLIENT CHECK LIST FOR PROBLEM AREAS AND SENSITIVE AREAS

THE FOLLOWING LISTS THE BODY AREAS COVERED IN A FULL BODY MASSAGE. PLEASE PUT AN "X" NEXT TO ANY PROBLEM AREA YOU WOULD LIKE PARTICULAR ATTENTION PAID TO. PLEASE PUT AN "O" NEXT TO ANY SENSEITIVE AREA THAT YOU WANT TO BE AVOIDED.

Head____	**Upper Back____**	**Chest____**	**Glutes____**
Face____	**Mid Back____**	**Thorax____**	**Thighs____**
Neck____	**Low Back____**	**Abdomen____**	**Lower Legs____**
Feet____	**Shoulders____**	**Arm____**	**Forearm____**
Wrist____	**Hand____**	**Sacrum____**	**Pelvis____**

PLEASE USE THE LINES BELOW TO DETAIL ANY PROBLEM AREAS YOU FEEL NEED FURTHER EXPLANANTION:

_____

_____

_____

_____

_____

_____

_____

This form is a way for me, the therapist to get to know you, their client better and to serve your needs. Please fill it out as honestly and fully as you can. All information given both in writing and verbally will be kept in the strictest confidence.

Disclaimer: I do not diagnose or prescribe within the context of our massage therapy session.

Therapist Signature:_____