All information is kept confidential. Please answer to the best of your ability.

Name: _____Birthday: _____

Street Address: _____

City/State: _____Zip: _____

Phone/Cell: _____ E-mail: _____

Whom may we thank for your referral? _____

Do you have a history of any of the following conditions: (Please circle all that apply):

Blood Clots Cirrhosis of the Liver Deep Vein Thrombosis (DVT) Cancer Diabetes Embolism

Hypertension Intestinal Obstructions Kidney Failure Lymphangitis Myocarditis

Pericarditis Pulmonary Embolism Tuberculosis

Please list any accidents, allergies, illnesses, injuries, and surgeries if not listed above:

_____

_____

If you are pregnant, please list how many weeks and due date: _____

Please list prescription medications and nutritional supplements you are currently taking and reason:

_____

_____

What is your occupation? _____

How often do you exercise/work out and type? _____

What level of pressure do you prefer? (This can be modified by letting your therapist know in session). Circle all that apply: Light/surface medium/surface heavy/deep very heavy/deep

I am aware I should seek the services of a licensed health care professional when needed and I should inform my primary health care giver of any concern altering my health status. I understand the procedures and techniques offered here are not intended to replace any medically prescribed treatments, nor will I receive or solicit any information that may be considered as a diagnosis or treatment of any disease. I also understand the session is for therapeutic and esthetic purposes only and any inappropriate advances toward the therapist or staff will result in termination of the sessions immediately. I understand my card on file may be charged full price, or my package or gift certificate may be redeemed for missed or late appointments not canceled within 24 hours' notice (aside from inclement weather, emergencies, and illnesses).

Signature: _____ Date**:** _____