



Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Occupation \_\_\_\_\_

Email Address \_\_\_\_\_

Have you ever had massage? \_\_\_\_\_ If yes, where and when? \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone number \_\_\_\_\_

**Current Condition**

Main problem(s) you would like help with today \_\_\_\_\_

\_\_\_\_\_

How long ago did the problem(s) begin-please be specific \_\_\_\_\_

\_\_\_\_\_

To what extent does the problem(s) interfere with your daily activities? \_\_\_\_\_

What kinds of treatments have you tried? \_\_\_\_\_

What medications (drugs, herbs, vitamins, etc.) are you currently taking? \_\_\_\_\_

- |   |     |    |
|---|-----|----|
| Do you wear contact lenses or dentures?-----  | Yes | No |
| Are you sensitive to perfumes, lotions, or oils?-----                                       | Yes | No |
| Do you exercise regularly or participate in any sports?-----                                | Yes | No |
| Do you have any skin problems or allergies?-----  | Yes | No |
| Do you have any heart problems?-----  | Yes | No |
| Do you have high blood pressure?-----   | Yes | No |
| Do you have low blood pressure? -----   | Yes | No |
| Do you have varicose veins or blood clots?-----   | Yes | No |
| Do you have arthritis, osteoporosis, brittle bones, or spinal problems?-----                | Yes | No |
| Do you have any lung or breathing problems?-----  | Yes | No |
| Do you have digestive tract problems?-----  | Yes | No |
| Are you pregnant?-----  | Yes | No |
| Have you suffered any acute injuries, illnesses or been hospitalized in the last year?----- | Yes | No |
| Do you have diabetes?-----  | Yes | No |

