

Please indicate all conditions you have experienced. Mark C for current or P for past.

Reproductive:

- Pregnant due date _____
- Post-menopausal
- Painful Menstruation
- Birth control type _____
- Heavy Flow
- Irregular Cycle
- Swollen Breasts
- Menopausal
- Pre-menopausal

Respiratory:

- Chronic Cough
- Bronchitis
- Asthma
- Hay Fever
- Difficulty Breathing
- Smoking
- Emphysema
- Pneumonia

Lifestyle Questions

- Regular eating habits Yes No
- Do you take vitamins: Yes No
- Type: _____
- Frequency: _____
- Regular exercise Yes No
- Type: _____
- Frequency: _____

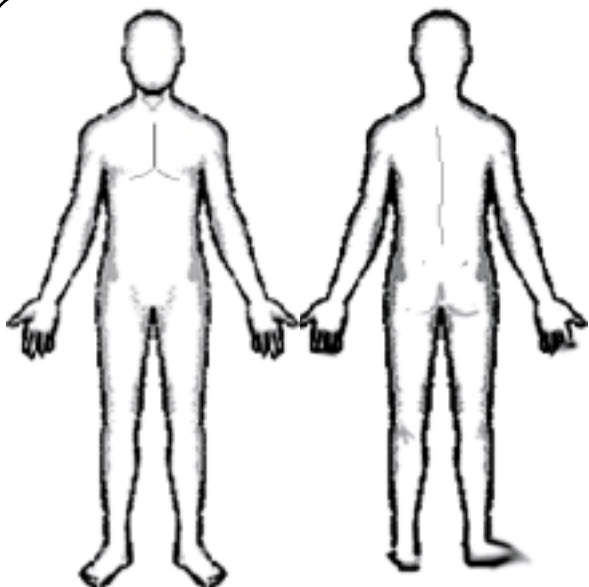
- Energy Level: High Average Low
- Do you suffer from stress? Yes No
- Type: _____
- Do you use a computer? Yes No
- How many hours per day: _____

Please read carefully, and sign.

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I consent to therapeutic massage treatment by the above named massage therapist.
- I also understand that I am responsible for any charges incurred in the course of my treatment.
- I understand that 24 hours notice is required to reschedule all future appointments, or full charges will apply.

signature

today's date



circle any focal areas

This area to be filled out by the therapist.

Duration of Massage: _____ Cost: _____

Techniques Used: _____

Comments: _____

Self Care Recommendations: _____
