Massage Therapy • Postural Alignment

Date_____

Name_____ Phone #_____

Address_____ City _____

Zip Code_____ DOB _____/_____/_____

Email Address_____ Profesion _____

Emergency Contact Name_____

Phone Number _____ Relationship to you_____

How did you hear about us?_____

Are you currently receiving any medical treatment? □No □Yes _____

What do you attribute your condition to?_____
Example: An Accident, A Fall, Arthritis etc.

How long have you had this pain/injury?_____

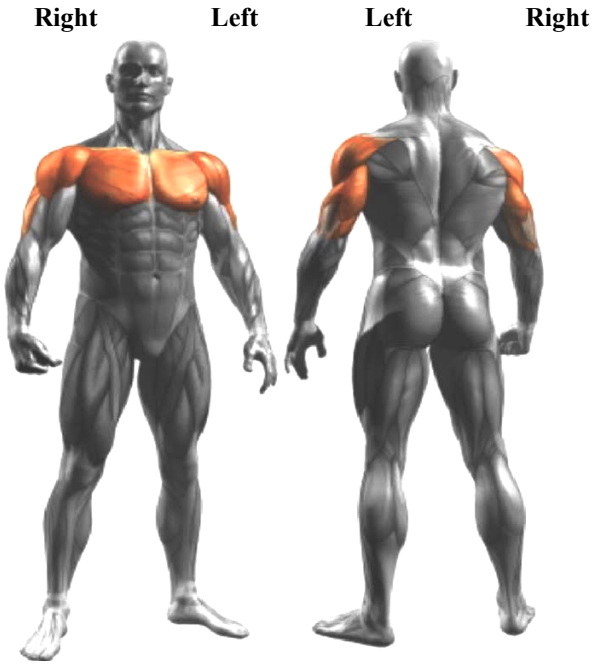
Is it difficult for you to lay on any of the following areas?

□Face Down □Face Up □Either Side

Are you allergic to oils, lotions or ointments? □No□Yes, Which?_____

Are you involved in any physical activity? □No□Yes, Describe?_____

MARK EACH AREA OF DISCOMFORT OR PAIN



Please Read and Check off

☐ 24-hour notice is required for cancellation or rescheduling of appointments, Or a penalty will be charged.
☐ I verity that all information is correct to the best of my understanding. I understand that my massage treatment is not a substitute for medical treatment and I should seek medical or chiropractic care for any physical condition. I agree to keep the therapist informed of any changes in my medical profile and understand that there will be no liability on the part of the therapist.
☐ I give consent to receiving treatment services at my own risk. I agree that it is a therapeutic bodywork session and comment or sexual advances will result in **IMMEDIATE TERMINATION OF THE SESSION AND WILL NOT BE ALLOWED IN THE ESTABLISHMENT FROM THAT MOMENT THEREFORE.** I will be responsible for the full payment of the sessions already paid.

_____ _____

Signature If minor Tutor Signature

THANK YOU FOR YOUR VISIT TO DIVINE POSTURE