Massage On Whitney

Name_____ Date Of Birth_____

Address_____City_____State_____

Email_____Phone_____

Occupation_____

Please indicate any of the following that apply to you:

Arthritis	Blood Clots	Cancer
Diabetes	Fibromyalgia	Heart Attack
Joint Replacement	Kidney Dysfunction	Low High BP
Migraines/ Headaches	Neuropathy	Numbness
Recent Injury	Recent Surgery	Skin Condition
Sprains/Strains	Stroke	Other_____

Please indicate any medications you are taking:_____

Have you had a massage before? Y N

Are you currently pregnant? Y N How far along_____ Risks_____

Any allergies_____Sensitivities_____

How did you hear of us?_____

Emergency Contact_____ Phone_____

I understand this is a non-sexual massage. I understand that nothing in this session is intended to treat, diagnose, or substitute medical attention. I attest that the above information is true and accurate to the best of my knowledge and agree to inform my therapist if any of the above information changes.

Signature_____ Date: _____