



Personal Information and Health Data Sheet

Name _____

Address _____

City _____ State _____ Zip _____

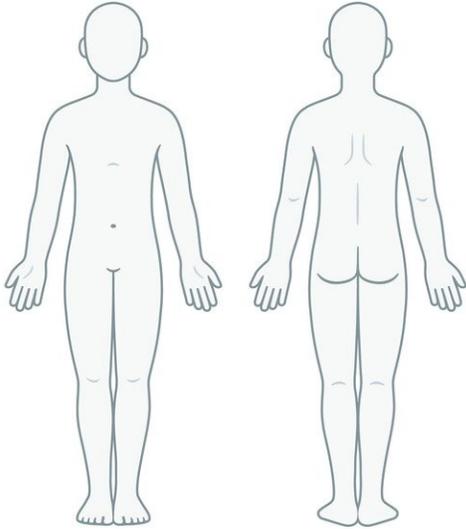
Email _____ Birthday _____

Phone _____ Can receive text? Yes No

Emergency Contact _____ Phone _____

Emergency Contact Relationship _____

How did you hear about us? _____



Indicate sensitive areas, areas of pain, areas to place focus, or areas you wish to avoid on the diagram or list below.

What do you wish to accomplish on your visit today? _____

How often do you receive massages? _____

List any pre-existing diseases or medical conditions _____

Are you pregnant? No Yes - How far along? _____

Would you like to receive our newsletter and discount specials? Yes No

I understand that payment is due at the time of service. The service will be completed professionally by a licensed and insured massage specialist. Therefore, I will not hold the service provider nor AZ Bodies in Balance, LLC responsible should any reaction occur during or after the service.

Signature _____ Date _____