Confidential Information

Welcome. We want to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your therapy session, please let us know.

Name_____Home#_____Cell #_____
Address_____City_____State_____Zip_____
Date of Birth_____Age_____M____F____
Occupation_____Referred by_____
Have you ever received massage therapy? Yes____ No____ Email:_____
Type of massage experienced: _____
Are you taking medication?_____ Describe_____

Do you have a history of any of the following?

accident	sprains	mastectomy	
neck pain	seizures	breast augmentation	
whiplash	diabetes	abdominal pain	
headaches	stroke	nervous tension	
shoulder pain	arthritis	varicose veins	
upper back pain	heart attack	high blood pressure	
mid back pain	colitis	allergies to oils	
low back pain	surgery	wear contacts	
joint aches	scoliosis	HIV	
sciatica	broken bones	fibromyalgia	
carpal tunnel	decreased range of motion	Other_____	

Please indicate your consumption level:

	None	Light	Moderate	Heavy
salt	_____	_____	_____	_____
sugar	_____	_____	_____	_____
caffeine	_____	_____	_____	_____
water	_____	_____	_____	_____
tobacco	_____	_____	_____	_____
alcohol	_____	_____	_____	_____
exercise	_____	_____	_____	_____

Please list any significant accidents in your personal history.
_____

Please list surgical history. _____

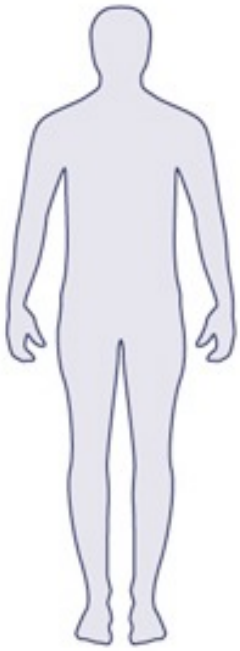
At my age and in my experience, I have had too many women friends with breast cancer. I have come to realize that it is time for me to overcome any cultural training that inhibits me from delivering a treatment that serves the whole body. I have long known the amazing results achieved by John Barnes, PT in working with women diagnosed with breast cancer. We are now including breast traction and nipple traction in the best interest of our client's health. If you do NOT wish for me to do this, please initial here _____.

Please inform your therapist if you have any skin problems or conditions (Sunburn open cuts, bruises, burns, inflammation, irritated skin, rash).

What are your goals/expectations for this therapy session?
_____
_____
_____

Please indicate with an “X” the areas you are feeling discomfort.

FRONT



BACK

Please read the following and sign below:

- I understand this massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

Date_____Signature_____