Please take a few minutes to fill out this short form, as completely as possible, so that I can get to know you better and fulfill your expectations more completely.

Name_____ Date_____

Address_____ City_____
Zip Code_____ Phone # ( ) _____
Cell # ( ) _____
Occupation_____ Birthday_____
Referred by _____
Emergency Contact:_____

Insurance information_____
SS#_____ Group # _____
Name of insured _____
Birthday_____ Relationship_____

When was your last full body massage? _____
Why are you seeking massage therapy? _____
What are your main areas of tension or pain? _____
_____
**Are you allergic to any kind of aromas? _____
How often do you see a chiropractor? _____

**Massage affects every system in the body, so please circle all medical conditions you presently have, and all serious conditions you have had in the past, such as:

☐Heart conditions	☐Cancers	☐Fractures	☐Chronic pain
☐Contagious diseases	☐Diabetes	☐Pregnancy	☐Surgeries
☐Vascular conditions	☐Arthritis	☐Osteoporosis	☐Stroke
☐High blood pressure	☐Other_____		

**Are you taking any kind of medication? _____
Why? _____

Please briefly describe any accidents or injuries: _____
_____

Do you feel your stress is more: Physical (labor/work) _____
Mental (think/worry) _____ Emotional (love/family) _____
Chemical (diet/drugs) _____

What kind of exercise do you do? _____
Do you: Stretch _____ Take Supplements _____
Have a healthy diet? _____
Have you ever done an internal or detox program? _____
What's your favorite way to relax? _____

I understand that I will be responsible for paying any charges not covered by insurance, and that I will be charged a full fee for missed appointments. Also if I need to cancel my appointment I need to call 24hours before.

I certify that I have read and understand the above information to the best of my knowledge. I authorize and request my insurance company to pay directly to this office or for Chiropractic/Massage treatment if I need one.

Signature_____ Date_____