CONFIDENTIAL INFORMATION

Name: _____ Home Phone: _____ Work Phone: _____

Email: _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ M/F _____ Marital Status _____

Occupation_____Referred by _____

Have you ever received massage therapy? Yes ❑ No ❑

Type of massage experienced: ❑ Deep Tissue ❑ Relaxation/Swedish ❑ Other: _____

Are you taking medication? Yes ❑ No ❑

If so, please describe: _____

_____

Have you consumed alcohol in the past 24 hours? Yes ❑ No ❑

DO YOU HAVE A HISTORY OF THE FOLLOWING?

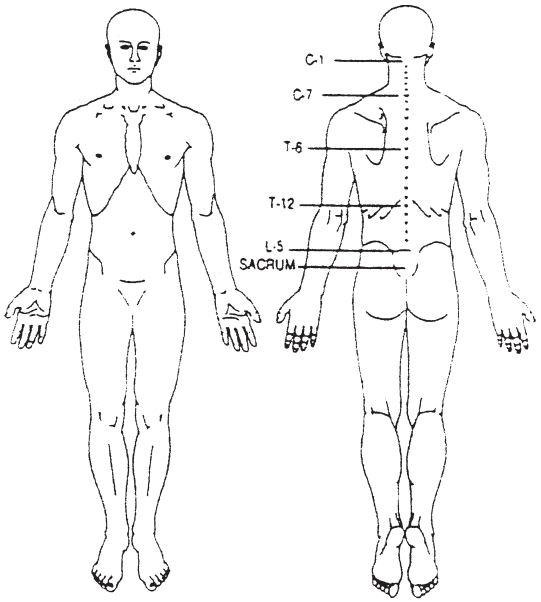
❑ Accident ❑ Sprains ❑ Fibromyalgia
❑ Neck Pain ❑ Seizures ❑ Breast Augmentation
❑ Whiplash ❑ Abdominal ❑ High Blood Pressure
❑ Headaches ❑ Mid Back Pain ❑ Varicose Veins
❑ Disk Problems ❑ Arthritis ❑ Bursitis or Gout
❑ Joint Ache ❑ Diabetes ❑ Nervous Tension
❑ Allergies to Oils ❑ Stroke ❑ Mid/Low Back Pain
❑ Heart Attack ❑ Cancer ❑ Decreased Range of Motion
❑ Broken Bones ❑ HIV ❑ Contacts/Glasses
❑ Surgery _____

DO YOU HAVE ANY OF THE FOLLOWING TODAY:

❑ Sunburn ❑ Open cuts, bruises, burns
❑ Inflammation ❑ Irritated skin rash
❑ Severe pain ❑ Poison ivy
❑ Headache ❑ Cold or flu

_____
_____
_____

Please circle, on the figures above, the places that are giving you discomfort.



	None	Light	Heavy
Salt	❑	❑	❑
Sugar	❑	❑	❑
Caffeine	❑	❑	❑
Tobacco	❑	❑	❑
Alcohol	❑	❑	❑
Exercise	❑	❑	❑
Water	❑	❑	❑

Please check one of the above for each catagory:
None, Light or Heavy

PLEASE READ THE FOLLOWING AND SIGN BELOW:

☞ I understand that 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
☞ I understand Marsha Cook operates independently as a sole proprietor.

Signature: _____ Date: _____

Welcome, I want to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your visit, please let me know.