

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Reason for Visit \_\_\_\_\_

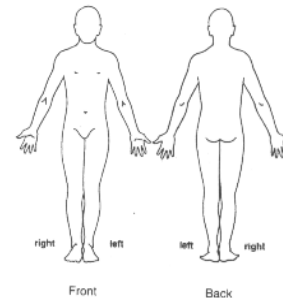
How did you hear about us?  Brochure/Flier  Email Newsletter  Expo/Event  Gift Card  Internet Search  
 Newspaper/Magazine/Program  Radio  Yellow Pages  Another Person: \_\_\_\_\_

Have you had any surgery, injuries or accidents in the past 6 months? \_\_\_\_\_

Please check any of the conditions listed below which you have experienced or that you believe may limit your ability to participate in physical activity.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Headaches/Migraine      | <input type="checkbox"/> Osteoporosis             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Pins/wires in your body  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Pregnancy (current only) |
| <input type="checkbox"/> Blood Clots/Phlebitis   | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Sciatica                 |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Hip Problems            | <input type="checkbox"/> Sinus Problems           |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Skin Problems            |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Knee Problems           | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Edema (water retention) | <input type="checkbox"/> Neck/Spine Injury       | <input type="checkbox"/> Thrombosis               |
| <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Numbness                | <input type="checkbox"/> Varicose Veins           |

Please indicate any problems areas you're experiencing today on the figures below.



Are there any other medical conditions that we should be aware of? \_\_\_\_\_

Have you received massage therapy before?  Yes  No Depth of Pressure desired: ← Light ---- Medium ---- Deep →

While working abdominal and/or pec muscles, do you prefer:  Breast Draping  No Breast Draping  No Preference

Do you have allergies to oil or fragrances? \_\_\_\_\_

From time to time, we send out information by e-mail. May we add your e-mail address to our list?

Yes, please!  No, thank you.

**I understand that the therapy provided here is for the purpose of stress reduction, relief from muscular tension or spasm, increasing circulation and energy flow, and/or relief from stiff joints. I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder. I understand that this information may be shared with other health care professionals within Mountain Waves for coordination of treatment. I take it upon myself to update the staff regarding any changes in my condition. I have read the above information, have stated all my known medical conditions, and agree to the terms of the above statement.**

**Guest's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Therapist's Signature \_\_\_\_\_ Date \_\_\_\_\_

For Office Use:  Ref Credit