Heaven & Health, LLC

CONFIDENTIAL INFORMATION

Name_____ Best telephone #_____ (h/w/c)

Address_____ City_____ State_____ ZIP_____

Email address_____ Occupation _____

Marital status_____ Date of Birth_____ Age_____ M__ F__

Referred by_____

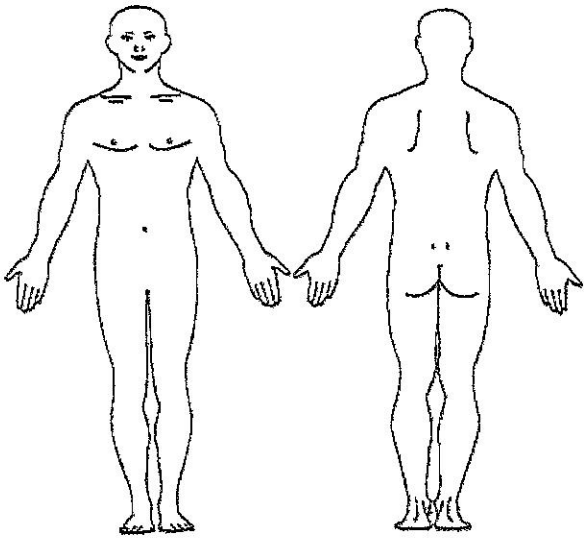
Have you ever received massage therapy?_____ Type of massage experienced:_____

Are you taking medication? If yes, please list_____

Do you have a history of the following?

- ☐ Accident
- ☐ Neck pain
- ☐ Whiplash
- ☐ Headaches
- ☐ Disc problems
- ☐ Mid-back pain
- ☐ Low-back pain
- ☐ Joint ache/pain
- ☐ Varicose veins
- ☐ Surgery
- ☐ Arthritis
- ☐ Diabetes
- ☐ Seizures
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Sprains
- ☐ Decreased range of motion
- ☐ Broken bones
- ☐ Fibromyalgia
- ☐ Cancer
- ☐ Taking blood thinners
- ☐ Nervous tension
- ☐ Allergies to perfumes/oils

Please indicate with an X the place you are feeling discomfort



Do you have any of the following today?

- ☐ Inflammation
- ☐ Pain
- ☐ Headache
- ☐ Open cuts, bruises, burns
- ☐ Skin rash
- ☐ Cold/flu/fever

Results would you like from your massage today?

- ☐ Relaxation
- ☐ Pain relief
- ☐ Stress relief
- ☐ Other: _____

Date_____ Signature_____

For office use only

WS _____
ML _____
BL _____
QB _____
NL _____
EM