
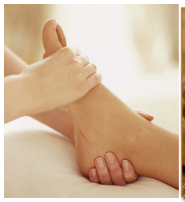



Name: _____ Birthdate: _____

Address: _____

Phone: _____ Email: _____

Would you like to be added to a monthly newsletter? _____

Reason For Visit/ Focus: (relaxaction, injury, pain) _____

Recent/Old Injuries,Surgeries,Accidents or Medical Treatment? _____

_____

Who may I thank for a referral? _____

Please Circle any of the items below that relate to you:

Sensitive/Skin Allergies	Neck/Spine Injury	High Blood Pressure	Liver Stress
Heart Condition	Cancer	Grief/Depression	Fatigue/Low Energy
Stress	Arthritis	Headache/Migraines	Bruise Easily
History of Blood Clots	Sciatica/Leg pain	Diabetes	Pregnancy
Bulging/Ruptured Disk	Jaw Pain/TMJ	High blood Pressure	Contagious Diseases

Medications: _____

Any Addional Infomation you would like to add:

_____

_____

I have informed Lisa Young of all my known physical, medical coditions and medications. And I will keep her up to date on any changes in my health. I understand that there shall be no liabillity on Lisa due to not relaying any pertinent infomation. If I expereince any discomfort during the session I will immediately communicate with Lisa so the treatment can be adjusted. I understand that massage is intended to enhance relaxation, reduce pain caused by muslce tension, increase range of motion and offer a positive experience of overall well being and health. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones nor is massage therapy a substitute for medical attention or examination.

Signature: _____ Date: _____