APPLICATION FOR TREATMENT

Mr___ Mrs___ Ms___ Date of Birth___/___/___ _____

Name (last)_____ (first)_____ (m)_____

Address_____City_____State_____Zip_____

Phone (___)_____ Work (___)_____ Cell/pg#_____

Email address_____ Occupation_____

In case of an emergency please notify _____#_____

Have you ever had a massage before ? Y or N Where ?_____
How did you find out about us ?_____

What is your major complaint(s) ? _____

How long has this been a problem ?_____

What makes this condition worse ? _____

Are you under a physicians care ? If so who ?_____

For what conditions ? _____

Please list all injuries/surgeries _____
_____

Medications_____

_____

Please check all that apply

allergies ___	disc problems ___	paralysis ___	hiv/aids ___
anemia ___	emphysema ___	pregnancy ___	osteoporosis ___
arthritis ___	epilepsy ___	stroke ___	headaches ___
asthma ___	fractures ___	thyroid ___	swelling ___
blackout ___	heart ___	varicose veins ___	smoke ___
bleeding ___	hernia ___	fibromyalgia ___	use alcohol ___
cancer ___	high blood pressure __	lupus ___	use caffeine ___
diabetes ___	muscle pain ___	stomach ___	other_____

I authorize treatment for massage at Heart & Soul Massage Therapy, Inc. and have completed this form to the best of my knowledge. I understand that massage does not take the place of medical care when indicated.
Signature_____ Date _____