

Penny Rump, LMT  
7413 US 42 Suite 3  
Florence, KY 41042

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: F \_\_\_ M \_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

How did you hear about me?

Friend/Family(who) \_\_\_\_\_ Healthcare Provider: \_\_\_\_\_

Internet: \_\_\_\_\_ Yellow Pages: \_\_\_\_\_ Other: \_\_\_\_\_

Please list all medications that you are taking \_\_\_\_\_

\_\_\_\_\_

Please list all medical conditions you have \_\_\_\_\_

\_\_\_\_\_

Drug Allergies: \_\_\_\_\_

By signing this form I give me consent to receive a massage. I understand I may discontinue the session at any time. I realize that the treatment is given for the well-being of my mind and body. All information will be kept in strict confidence. I have stated all medical conditions that I am aware of and will update the therapist of any changes in my health status.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_