

Please mark if you have had any of these conditions (please include the date that the condition occurred)

_____ Broken Bones	_____ Kidney disease
_____ Epilepsy	_____ Hepatitis
_____ High/Low Blood Pressure	_____ Headaches
_____ Diabetes	_____ Numbness in Extremities
_____ Heart Disease	_____ Respiratory Disorders
_____ Arthritis/Osteoporosis	_____ Fatigue
_____ Back Pain/Problems	_____ Anxiety
_____ Allergies/Sinus Problems	_____ Neck Pain/Problems
_____ Mood Swings	_____ Tuberculosis
_____ Thyroid Disorders	_____ Aneurysm
_____ Phlebitis (blood clots)	_____ Skin condition
_____ Cancer Type _____	
_____ Aids/HIV Treatment _____	
_____ Pregnant Due Date _____	

Surgery (within the last 2 years or still affecting your life) _____

What brings you here today? _____

Have you ever had a professional massage? Was it a good experience? _____

What results would you like to see achieved today? _____

Check all that apply and rate the level of pain experienced (1 is the least, 10 is the most)
 I experience pain:

	Daily	Weekly	Occasionally (When?)	
Ankles	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Arms	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Back	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Feet	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hands	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Head	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Hips	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Joints	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Legs	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Muscles	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Neck	_____	_____	_____	1 2 3 4 5 6 7 8 9 10
Other	_____	_____	_____	1 2 3 4 5 6 7 8 9 10