## Silver Leaf Massage



Please fill out all information as accurately and thoroughly as possible. The following information will be used to help plan safe and effective massage sessions.

Date:			
Name (Printed):	Date of Birth:		
Home Phone:	Work Phone:		
Cell Phone:			
Address:			
City:			
E-mail Address:			
Occupation:			
Hobbies:			
Emergency Contact (and their relation Phone:	nship to you):		
And are you currently under medical s  If yes, please explain:		• •	
Chiropractor and how often you go:_			
How do you relieve stress or pain?			
What are the reasons for your visit to	day?		
List any reason you are taking medica	ation for:		
Do you have any allergies?			

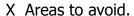
Do you exercise? ( )Yes ( )No Please describe what type of exercise.	se and how often:	
Is it okay to work on: ( )All ( )Head ( )Face ( )Pecs ( )Abdome	on ()Leas ()Eest ()Arm	as ( )Back ( )Glutes
( ) lead ( ) lace ( ) recs ( ) Abdolle	ii ()Legs ()i eet ()Aiii	is ( )back ( )diutes
You prefer pressure that is: ( )Light	( )Moderate ( )Moderat	e/Firm ( )Firm
Use $\underline{C}$ for current and $\underline{P}$ for past. Ma	ark any or all that apply.	
Arthritis Blood Pressure High Blood Pressure Low Circulatory Problems Pregnant Skin Problems Teeth Grinding Whiplash	Diabetes	Sinus Problems
Have you had broken bones or dislo	cations? ( )Yes ( )No	
Do you have ( )Numbness or ( )State	obing pains anywhere?	
If yes, please list, include year:		
List all surgeries and when:		
List all accidents you have had, and	when:	
Do you have a history of cancer?:		
Do you have any other medical cond	ditions?	
Have you ever had a professional m If yes, when/how often:		

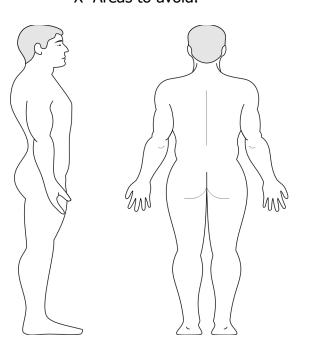
Trust your body to express what it needs to do: Moving, Changing Positions, Sighing, Yawning, Change In Breathing, Stomach Gurgling, Emotional Feelings, Energy Shifts, Falling Asleep and/or Memories.

Please read the following information and sign below:

- 1. I understand that although massage therapy can be very therapeutic, relaxing and reduces muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
- 2. As massage can not be done safely under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully. I will keep my practitioner informed of any changes.

Patient Signature:	Date:
How did you hear of us? For each person referred you will receive a coupon for \$10	O off your next massage.
Consent for Treatment of a Minor: By my signature below, Silver Leaf Massage Therapy to massage my child or depend Parent or Guardian:	





O Areas to focus on.

