GREEN SERENE
MASSAGE

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If you have any questions regarding your session, please let me know.

Name:_____ Date of Birth:_____ Occupation:_____

Address:_____ Phone:_____

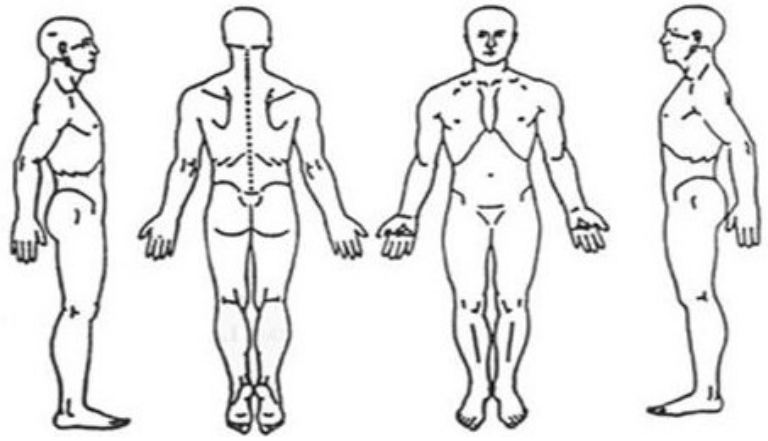
Emergency Contact: _____

Have you ever received massage therapy? _____Yes _____No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.)_____

What kind of pressure do you prefer? _____ Light _____ Medium _____Firm

If you have areas you feel discomfort, please indicate with and (X):



Goals: What are your goals/expectations for this therapy session?

Areas to avoid *(circle if any)*: Face Head/Hair Feet Stomach Glutes Other:

Medications ~ Are you currently taking any? _____ Yes _____ No
If yes, please list name and reason for medications:

Healthcare professional ~ Are you currently seeing one? _____ Yes _____ No
If yes, please list names and reason/treatment:

Allergies ~ Do you have any to:

____ medications ____ foods (nuts, etc.) ____ reactions to skin care products
____ environmental allergens (dust, pollen, fragrances)
If yes, please list details:

Health ~ please review this list and mark only those conditions that have affected your health. Mark with "C" for current conditions and "P" for past conditions.

____ arthritis
____ auto immune condition *
____ back problems
____ blood clots
____ broken bones
____ bruise easily
____ cancer
____ chemical dependency
____ chronic pain
____ constipation
____ depression, panic disorder, other psych condition
____ diabetes
____ diarrhea
____ diverticulitis
____ dizziness, ringing in the ears
____ endocrine, thyroid condition
____ headaches
____ heart condition
____ hepatitis (A,B,C, other)
____ high blood pressure
____ insomnia
____ kidney disease, infection
____ memory loss
____ muscle strain/sprain
____ neurological (eg. MS, Parkinson, chronic pain)
____ numbness or tingling
____ osteoporosis, degenerative spine/disk
____ pregnancy
____ seizures, epilepsy
____ scoliosis
____ shortness of breath
____ skin conditions
____ stroke
____ surgery
____ TMJ disorder
____ varicose veins

* (AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If marked, please explain:

Other ~ Do you have any of the following today:

____ skin rash ____ cold/flu ____open cuts ____ severe pain
____anything contagious ____ injuries/bruises

Any other health conditions or anything else to share, please do so:

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain of discomfort during the session, I will immediately inform the therapist so that the pressure and/or stokes may be adjusted to my comfort level.

I further understand that this massage or anything sold in the course of the sessions is not a substitute for medical examination, diagnosis, or treatment.

Because masage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all the questions honestly. I understand that there shall be no liability on the therapist's part if I fail to do so.

Signature of client _____ Date: _____