MASSAGE LITTLE ROCK

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____
(Massage Little Rock will be using email to keep in touch with patients. We never rent or sell your email addresses, and it will always be kept private. Providing this information constitutes your permission for Massage Little Rock to contact you regarding information via mail, e-mail, fax, or phone.)

PHONE #: _____ WORK #: _____ OCCUPATION: _____

HOBBIES , SPORTS, OTHER ACTIVITIES: _____

Do you presently have any of the symptoms below:
Please Circle all that apply.

Neck pain	Contact Lenses	Ankle or foot pain
Lower back pain	Shoulder pain	Heart disease
Mid back pain	Radiating Leg pain	High blood pressure
Upper back pain	Tingling	Low blood pressure
Numbness	Ringing of ears	Varicose veins
Blurred vision	Hip pain	Edema
Knee pain	Leg numbness	Diabetes
Epilepsy	Nausea	Cancer (in remission?) _____
Gout	Arthritis	

If female, are you pregnant? _____
Have you had any recent traumas or surgeries? _____
Do you have a pacemaker, heart or circulatory condition? _____
Is there **ANY** condition that you know about that may make massage contra-indicated for you?
_____
Have you had massage therapy before? _____
Do you think you may have a need for therapeutic (massage) care? _____
Are you interested in finding out about getting continued massages at a low cost? _____
Would you like information about our Triactive laser cellulite reduction and skin tightening? _____

Please be advised that we do NOT provide the DISCOUNTED massages for THERAPEUTIC treatment. THERAPEUTIC treatment requires diagnosis, more involved record keeping and, as needed, insurance filing. I understand that the massage/body work I receive is provided for the purpose of relaxation, stress reduction, and relief of muscular tension. If I experience pain or discomfort during my session, I will immediately inform the therapist so that the pressure and or strokes may be adjusted to my level of comfort. I further understand that the massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a medical physician, chiropractic physician, or other qualified health care specialist for any mental or physical ailment. This service does NOT include writing letters to employers, attorneys, insurance companies or other extra paper work. Because massage should not be administered under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

Client's Signature _____ Date_____