Massage Therapy Treatment Card

Name____________________ Occupation____________

Address____________________ Zip Code ____________

Home Telephone____________ Work Telephone____________ Cell____________

Birthdate____________ Refferred By____________ Gift Certificate?____________

Emergency Contact and Number____________ Physician____________

Primary Reason for Today's Appointment____________________

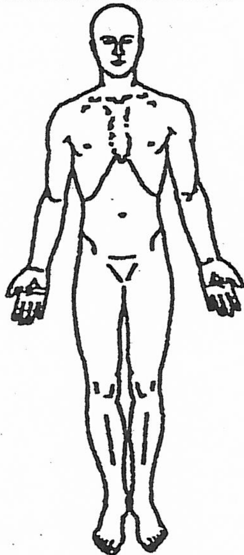
Please Circle All That Apply To You

Allergies	Diabetes	Painful/Swollen Joint
Anxiety	Digestive Problems	Pinched Nerve
Arthritis	Fibromyalgia	Pregnancy
Asthma	Headaches	Skin Conditions
Cancer	HIV	Sinus Problems
Chronic Fatigue	Insomnia	Spinal Problems
Chronic Illness	Migranes	TMJ Dysfunction

Surgeries:____________________

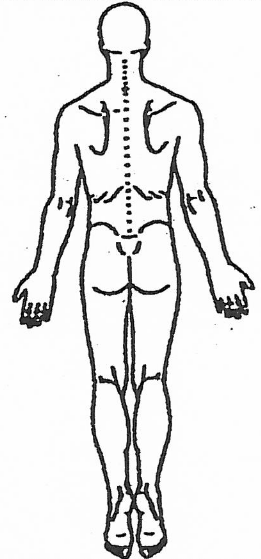
Accident/Injuries____________________

Please Mark Areas Of Muscle Tension With An "X"



Right

Left



Client Signature____________________ Date____________

Intake Therapist Signature____________________ Date____________

Respect Your Therapist ~ Please Give 24 Hours Notice For Cancellation

A Missed Appointment Fee of $25 May Be Charged Upon Missing or Canceling without Sufficient Notice