Name:

Guardian (if under 18):

Best Contact Phone #

How Did You Hear About Us:

What is You Email:
Yes to our Monthly Newsletter (specials, wellness advice, current events)

What is Your Date of Birth:
Yes to our Annual Birthday Deal

Gender: ____ **M** ____ **F**

Mailing Address:
We send a Thank You card

About You:
Occupation/ Exercise and/ or Daily Activities (How do you use your body?):

What types of Bodywork or Natural Methods of Healing have you Experienced?

Do you prefer light or deeper touch?

Are you currently seeking out treatment from other providers? Please Explain:

Are you taking Medication? PLEASE LIST:

Have you consumed more than 2 alcoholic beverages or prescription/ non-prescription drugs in the past 24hours? PLEASE LIST:

Today are any of these applicable?

- SUNBURN
- INFLAMMATION
- SEVERE PAIN
- HEADACHE
- WARTS
- COLD/ FLU
- SKIN RASH OR IRRITATION
- INFECTION
- OPEN CUTS/ BRUISES/ BURNS
- CONTAGIOUS CONDITION
- ANXIETY/ DEPRESSION
- PREGNANT
- UNDER DOCTORS CARE

Please indicate your usual level of consumption:

	NONE	LIGHT	MODERATE	HEAVY
SALT	☐	☐	☐	☐
SUGAR	☐	☐	☐	☐
CAFFEINE	☐	☐	☐	☐
TOBACCO	☐	☐	☐	☐
ALCOHOL	☐	☐	☐	☐
EXERCISE	☐	☐	☐	☐
WATER	☐	☐	☐	☐

MUSCULAR/ SKELETAL HISTORY (PLEASE CIRCLE):

HEAD/ NECK / SHOULDER/ MID BACK
LOWER BACK / SCIATICA
KNEES / ARMS / HANDS / FEET
SCOLIOSIS
ACCIDENT
WHIPLASH
HEADACHES
SURGERY
VERTEBRAL DISK ISSUES
JOINT ACHE
DECREASED RANGE OF MOTION
BROKEN BONES
ARTIFICIAL JOINTS / PINS / IMPLANTS
SPRAINS / STRAINS
ARTHRITIS / BURSITIS / GOUT
TMJ

MEDICAL HISTORY (PLEASE CIRCLE):

ALLERGIES / SENSITIVITIES
CONGESTION
DIGESTIVE CONCERNS
CHRONIC ILLNESS
NERVOUS TENSION
FATIGUE
SEIZURES
CANCER
HIV
HEART CONDITION (STROKE / ATTACK)
HIGH / LOW BLOOD PRESSURE
DIABETES
BLOOD CLOT
LYMPHEDEMA
ULCER
THYROID
HERNIA
DRUB / ALCOHOL DEPENDENCY
MAJOR SURGERIES