

CLIENT INFORMATION AND STATEMENT

NAME PHONE
STREET ADDRESS
CITY STATE ZIP

HEALTH INFORMATION

1. Have you ever had or been diagnosed as having problems with any of the following:

- | | | | |
|---------------------------------------|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Digestion | <input type="checkbox"/> Circulation |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Lungs | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Prostrate | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bleeding | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Nerves | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> PMS | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Ovaries | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Throat | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Breast | <input type="checkbox"/> Colon | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Bladder | <input type="checkbox"/> Spine/Back | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Spleen | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Edema | <input type="checkbox"/> Weight |

2. Occupation Date of birth

3. Are you allergic to any food or medication?

3a Do you have any allergies to nuts? yes no

4. Are you pregnant? yes no if so, how many months?

5. Are you under a lot of stress?

6. What conditions are you presently under a physician's care for

7. Please list any medications you are taking?

8. Do you know of any problems that you may have that may be aggravated by massage?

9. Please tell how you learned of our service

CLIENT STATEMENT

I understand that the massage therapy given to me by Phil Allamong is for the purposes of stress reduction, pain reduction, relief from muscle tension and increasing circulation. I understand that I may also receive information on nutritional matters that are intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

I understand that massage therapy does not diagnose illness or disease, or any other disorder, and that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy. I understand that massage therapy is not a substitute for medical examinations or medical care, and that it is recommended that I am concurrently working with my primary caregiver for any condition I may have.

I fully understand that those who treat and/or counsel me are not medical doctors or practitioners and I am not here for medical-diagnostic purposes or treatment procedures. I have stated all my known physical conditions, medical conditions, and medications, and I will keep the massage therapist up dated on any changes.

Signature

Date