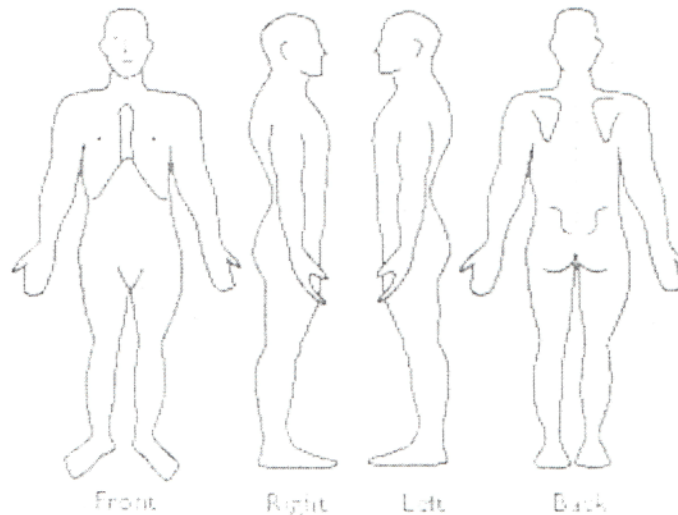


<b>Who is your primary care physician?</b>	<b>Are you currently receiving treatment from other health care professional? If yes, please describe.</b>
Name: _____	
Address: _____	
Phone: _____	
<b>List any other medical conditions not identified above</b>	<b>Please indicate the locations of any artificial joints, pins or wires</b>

**Mark the locations of any symptoms you are experiencing:**  
 Circle painful locations    **X** - stiff locations    **///** -- numbness, tingling



I certify that all the information provided is correct and complete. I understand and acknowledge that errors, or omissions, may effect the safety and/or efficacy of treatment.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Date	Initials

It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my mind and body. I agree to communicate with my practitioner any time I feel that my well being is being compromised. I understand that massage therapy practioners do not diagnose illness, disease or any other physical or mental disorder nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service.