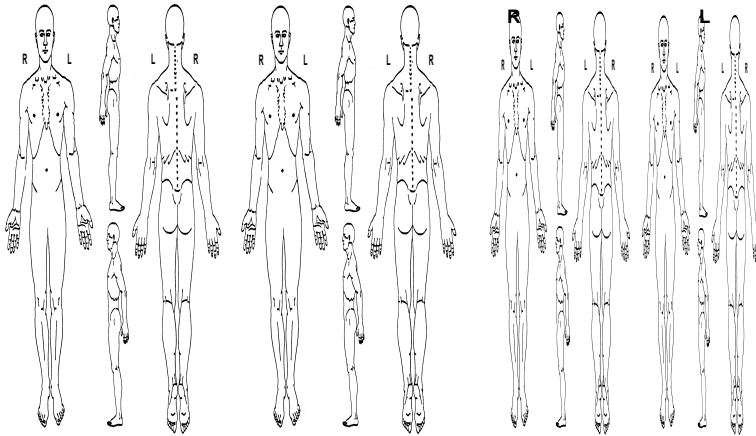




# First Visit History

## Clinic Use Only

Please color in your conditions, scars and injuries:



Notes:

List other therapies you currently receive: \_\_\_\_\_

Please list any additional comments regarding your health and well-being: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

The information I have provided is accurate and complete to the best of my knowledge. I understand that massage therapists do not diagnose or treat disease, and that any care or recommendation I receive in this clinic or from my therapist is not a substitute for a physician's care. I take responsibility for alerting my therapist of any changes to my health status, medications and therapies before the session, as well as any and all responses perceived to be a result of massage therapy as soon as I become aware of them. I understand that no sexual activity, comment or innuendo will be tolerated. This facility reserves the right to refuse services at their discretion based upon the client's conditions, therapist's skill set, client attitude or action, etc, without explanation or prior notice, and I agree to this policy. Cancellation within 24 hours of scheduled massages may result in charge of up to the full price of your intended session. You may contact me for appointment reminders, schedule changes, or other needs.

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