Thai Tibetan Aroma Oil Massage

Please assist us in getting to know you a little better as a first-time "Thai Tibetan" client.
Please fill out the following:

Name: _____ Birth Date: _____

Address: _____ City: _____

Postal Code: _____ E-Mail Address: _____

Phone Number: _____ Cell Number: _____

Emergency Contact Name & Phone Number: _____

In order to plan a massage session that is safe and effective, we need some general information about your medical history:

Health Condition	Y	N	Please Describe	Health Condition	Y	N	Please Describe
Asthma				Dizziness			
Liver Problems				Seizures			
Kidney Problems				Osteoporosis			
Constipation				Arthritis			
Heart Problems				Back Problems			
High Blood Pressure				Sciatica			
Respiratory Problems				Neck Problems			
Diabetes				Other Joint Problems			
Hypoglycemia				Neurological Problems			
Allergies				Other			
Eye Problems				Other			

For Women: Are you pregnant or planning to be? □Yes □No When is your due date? _____

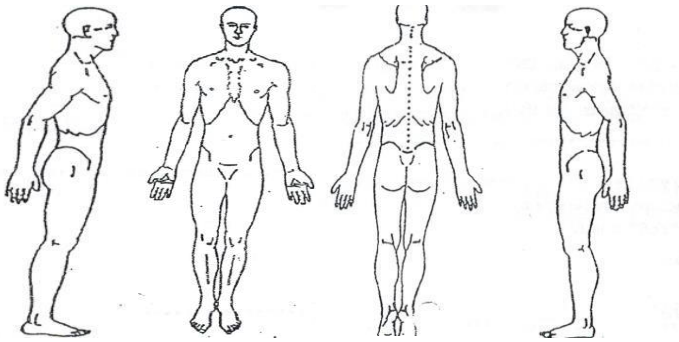
Have you had a Thai Massage before? □Yes □No

Do you have any physical limitations? □Yes □No
If yes, please explain: _____

Do you sit for long hours at work, using computer or driving □Yes □No
If yes, describe: _____

Do you experience stress? □Yes □No
If yes, does it cause you to have: □muscle tension □anxiety □insomnia □irritability
□other _____

Is there a particular area of the body where you are experiencing tension, stiffness or other discomfort?
□Yes □No If yes, please identify in location below and mark on the body drawing to show area of discomfort.



Pain or discomfort location:
□Headaches □Back □Neck □Shoulder □Abdomen □Hip □Pelvis □Groin □Buttock □Arm □Elbow □Hand □Leg □Knee □Foot □Other
Characteristic of pain: _____

Have you had a recent (acute) joint injury? □Yes □No If yes, please describe: _____

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? □Yes □No

In the past month, have you had chest pain when you were not doing physical activity? □Yes □No

Do you lose your balance because of dizziness or do you ever lose consciousness? □Yes □No

Do you have an auto immune illness? □Yes □No If yes, please describe: _____

Are you currently under medical supervision? □Yes □No

List any medications that you are taking _____

_____

Have you had any major or minor surgery within the past year? □Yes □No
If yes, please describe: _____

Is there anything else about our health history that you would like your massage practitioner to know in order to plan a safe and effective massage session for you? _____

_____ _____
Patient Name (PRINTED) SIGNATURE of Patient (Guardian)

_____ _____
Witness (signature) Date Signed