**Name:**  **Date:**

**Address:**

**City:**   **State:** **Zip:**

**Cell:**  **Email:**

**Occupation:**

**Primary Areas of Pain or Stress / Goal(s) of Massage:**

**Please list your current medications / surgeries / major illnesses / injuries:**

**Allergies:**

**Consent for Care:** It is my choice to receive massage therapy, and I give my consent to receive treatment. I understand this is not medical treatment or a substitution for medical care. I have reported all health conditions that I am aware of and will inform my practitioner of any significant changes in my health.

**Signature: Date:**