

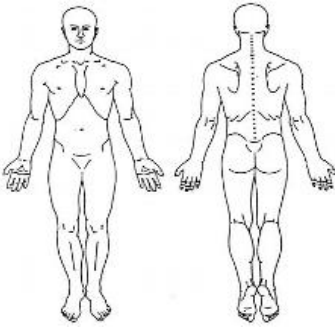
Please indicate any conditions that you are currently experiencing or have in the past:

| Past | Present | Condition | Past | Present | Condition |
|-----------------------|-----------------------|--|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Heart condition / High blood pressure | <input type="radio"/> | <input type="radio"/> | Osteoporosis / Broken, fractured bones |
| <input type="radio"/> | <input type="radio"/> | Varicose / Spider veins | <input type="radio"/> | <input type="radio"/> | Rheumatoid or osteo arthritis |
| <input type="radio"/> | <input type="radio"/> | Blood clots / Phlebitis | <input type="radio"/> | <input type="radio"/> | Bursitis / tendonitis / sprains |
| <input type="radio"/> | <input type="radio"/> | Asthma / Bronchitis / Respiratory Conditions | <input type="radio"/> | <input type="radio"/> | Diabetes |
| <input type="radio"/> | <input type="radio"/> | Ulcers or other digestive problems | <input type="radio"/> | <input type="radio"/> | Athlete's foot / skin infections / warts |
| <input type="radio"/> | <input type="radio"/> | Immune system function conditions | <input type="radio"/> | <input type="radio"/> | Kidney / urinary problems |
| <input type="radio"/> | <input type="radio"/> | Fibromyalgia | <input type="radio"/> | <input type="radio"/> | Hepatitis A, B, or C |
| <input type="radio"/> | <input type="radio"/> | Psychological disorders / Anxiety | <input type="radio"/> | <input type="radio"/> | Headaches / migraines |
| <input type="radio"/> | <input type="radio"/> | Allergy symptoms | <input type="radio"/> | <input type="radio"/> | Seizures |
| <input type="radio"/> | <input type="radio"/> | Excessive fatigue | <input type="radio"/> | <input type="radio"/> | Numbness / tingling / nerve degeneration / loss of sensory perception |
| <input type="radio"/> | <input type="radio"/> | Back/Spinal Problems / Sciatica | | | |

Please read the following information and sign below to indicate agreement:

- This is a therapeutic massage. Any sexual remarks or advances will terminate the session and I will be liable for the full payment for the scheduled treatment.
- I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any physical or mental ailment that I am aware of.
- Being that massage is contraindicated (should not be done) under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully. I agree to keep the massage therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.
- **Cancellation/Late Arrival Policy: I agree to provide at least 24 hours advance notice if I need to cancel an appointment, otherwise I will pay a \$30 cancellation fee. If I arrive late, I understand my session may be shortened and will be charged the full amount of my scheduled session.**

Client's Signature: _____ Date: ____ / ____ / ____

| | |
|---|---|
| For therapist's use: Date _____ Length of Session _____ | |
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