

Cecilia Mills
(814) 571-5916
calmpoint@gmail.com

Name _____ Date of Birth _____
Address _____ City/State/Zip _____
phone number _____ Cell phone _____
e-mail _____

Have you had a massage before? Yes or No

Please list illnesses, injuries or recent surgeries _____

Major area of discomfort _____

Please check if you have any of the following:

___ Back Pain/Stiffness ___ Neck Pain/Stiffness ___ Joint Pain

___ Knee Pain ___ Elbow Pain ___ Shoulder Pain

___ Varicose Veins ___ Numbness/Tingling? Where? _____

___ High or Low Blood Pressure ___ Skin Conditions _____

___ Diabetes ___ COPD/ Emphysema ___ Digestive Conditions _____

___ Allergies (please list type) _____

Other _____

I have completed this form to the best of my knowledge. I understand massage is only an aid to my health and in no way takes the place of a doctor's care. I agree to update my health information as needed with each session. I will let the massage therapist know if I am uncomfortable at any time.

I understand that payment is due to the therapist at the time of the massage appointment. Cancellations within less than 24 hours of scheduled appt. are subject to a 50 % fee.

Signature _____ Date _____