

DYNAMIC MASSAGE & BODYWORK

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(334) 699-6832

Name _____ Phone _____ Date _____

Address _____ City _____ Zip _____

Date of Birth _____ Email _____ Referred by _____

Occupation _____ Exercise Activities _____

1. Are you wearing contact lenses? Y or N
2. Do you have any open cuts, rashes, or bruising? Y or N
3. Are you currently experiencing a cold, flu, or other infection? Y or N
4. Your reason for massage therapy today _____

5. Describe recent or past injuries and medical treatments _____

6. Have you ever had or do you now have any of the following? If so, please circle item.

Accidental Injury	Cortisone Injections, Date: _____	Lower Back
AIDS/HIV	Chronic Pain	Lupus
<i>Arthritis</i>	<i>Diabetes</i>	
Blood Clot/DVT	Dislocated Joint	Neck/Whiplash
Cancer of Tumor	Fibromyalgia Syndrome	Neuropathy/Numbness
Chemotherapy/Radiation	Headaches/Migraines	Seizures
Date: _____	Heart Attack or Pacemaker	Stroke
Chronic Fatigue Syndrome	Kidney Disease	

7. List your current medications _____

8. Are there any other health issues I should be aware of? _____

Release and Consent: The above information is correct to my knowledge. I understand that massage therapists do not diagnose or treat disease. I take responsibility for alerting my therapist of any changes to my health status before each 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 hereby freely give my permission to be massaged.

Signature _____ Date _____