

Cardiovascular Conditions:

<i>General:</i>	Diabetes	Constipation (chronic or mild)
	Tire easily	Kidney problems
<i>Circulatory:</i>	High blood pressure	Varicose veins
	History of blood clots	Phlebitis
<i>Cardiac:</i>	Heart disease	Pacemaker
<i>Respiratory:</i>	Emphysema	Asthma
	Bronchitis	Shortness of breath

Explain: _____

Orthopedic Conditions:

Osteoporosis	Osteoarthritis	Rheumatoid arthritis
Musculoskeletal pain, stiffness, or stress		
Any joint, neck, back injuries, or fractures		

Explain: _____

Neurological Conditions:

Multiple sclerosis	Parkinsons	Cerebral palsy	Head injury		
Epilepsy	Stroke	Headaches	Inner ear disturbances		
<i>Emotional loss:</i>	Death	Disability	Trauma	Stress	Depression

Explain: _____

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for those services.

I also agree that massage therapy treatments are my personal financial responsibility and that I am to pay for those services at the time of treatment unless other written arrangements have been made, and that I must change or cancel appointments with at least 24 hours notice or I will be charged the full price of my massage.

Signed: _____

Date: _____

Please fill out this form and fax to the number below before your first session. If you don't have access to a fax machine, please bring form with you to your first session.

Fax Number: 503-590-2444