

New Client Information

Emerald Vine Massage

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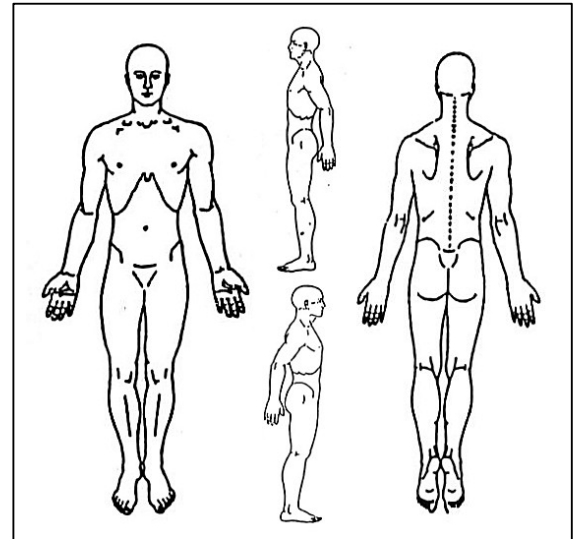
Name: _____
Date of Birth: _____
Occupation: _____
Phone: _____
Email: _____
Address: _____

How did you hear about us? Community Shopper
 Friend Flyer PCC Seattle Metro Mag
 Search Engine Walk/Bike By Other
Please Specify for 'Friend'/'Other': _____

Are you seeing a doctor for any reason? (N / Y)
Diagnosis: _____

Are you taking any medications? (N / Y)
Please Specify: _____

What are your current symptoms (please mark the figures to the right to indicate location)?



Please list current or past illnesses, medical conditions, injuries, surgeries, or accidents (broken bones, car accidents, etc.):

Have you had previous massage? How often? Do you have any favorite styles or likes/dislikes?

Do you have any short/longterm goals or desires for your massage session(s)?

To the best of my knowledge, I have truthfully and completely answered the above questions. I agree to pay all charges and copays at the time of service and, should I pay with a check that subsequently bounces, agree to pay the insufficient funds fee, as determined by the bank. I also understand that I must give a minimum of 24-hours notice to cancel my appointment time and that failure to do so will result in charges being made for the time reserved. While I may receive a reminder call in the days prior to my appointment, in the event that I do not receive this courtesy, I understand that I am still responsible for remembering my appointment time.

Signature: _____ Date: _____

Emergency Contact Information:

Name: _____

Relationship: _____

Phone: _____

Please indicate if you have/are any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Pregnant (or trying to become pregnant) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Cold, Fever | <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sprains, Strains |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Open Lesions, Cuts | |
| <input type="checkbox"/> Other | |

_____ Please Specify for 'Other' or 'Skin Condition:'