INSPIRING HANDS MASSAGE

Name:_______________________________Date of Birth:__________________________

Address:_____________________________City/State/Zip:__________________________

Phone Number:___________________________Email:_____________________________

Have you had a professional massage before? Yes No

Do you have an allergies to oils, lotions, or oinments? Yes No

Are you currently taking any medications that could effect a massage? Yes No

If yes please list:____

Please check and conditions listed below that applies to you:

Contagious skin condition	High/Low lood pressure
Open sores or wounds	Varicose Veins
Easy Bruising	Atherosclerosis
Recent Injury or accident	Blood Clots
Recent Surgery	Osteoporsis
Artificial Joints	Headaches/ Migraines
Heart Condition	Cancer
Diabetes	Carpal Tunnel
Tingling/ Numbness	Tennis elbow/ Golfers elbow
TMJ	Pregnancy; if yes how many weeks?