# Valerie Lindsey, LMT

(901) 428-0197

Appointment Time_____

Client Name_____ Date of Birth_____
Address_____ Referred by_____
City_____
Daytime Phone_____Cell Phone _____ Spouse Name:_____
Email_____ Anniversary_____

What Type of Work Do You Do?_____
What Sports Or Hobbies Do You Regularly Participate In?_____

List any medical or physical condition you have had during the last three years

Are you currently being treated by a physician or Chiropractor?_____
If so, please describe_____

Are you taking medication?_____ If so, please list_____

Have you ever had a professional massage?_____

Do you have any difficulty with the following?

| | | | |
|---|---|---|---|
| □ Fibromyalgia | □ Muscle spasms | □ Tingling | □ Constipation |
| □ Chest Pain | □ Pinched Nerves | □ Numbness | □ Dizziness |
| □ Heart Pain | □ Slipped Disk | □ Swollen Joints | □ Sinus trouble |
| □ Cancer | □ Herniated disk | □ Swollen ankles | □ Trouble sleeping |
| □ Diabetes | □ Shooting neck pain | □ Varicose Veins | □ Cold feet |
| □ Asthma | □ Grating in neck | □ Fatigue | □ Cold hands |
| □ Headaches | □ Shoulder tight | □ Nervousness | □ Fainting |
| □ Migraine headaches | □ Leg or foot pain | □ Cold sweats | □ Pregnant |
| □ Kidney Trouble | □ Irritability | □ Wear contact lenses | □ High blood pressure |

Certain medical conditions and symptoms may be CONTRAINDICATED for massage therapy, thereby requiring a referral from a primary care physician BEFORE receiving treatment. I affirm that I have stated all my known medical conditions and have answered all the questions honestly. I will inform the therapist of all changes in my medical profile. I understand that the treatments are NOT substitutes for medical examinations, diagnosis, or any other treatments by a qualified medical specialist. Massage therapists are NOT qualified to perform skeletal adjustments, or treat mental or physical illness and that nothing said in the course of treatment should be construed as such. If I experience any discomfort during treatment I will inform the therapist immediately.

_____ _____
Client Signature Date