Benessere
Acupuncture & Massage
In the comfort of your own Home

Client Information

In order to maximize the effectiveness and safety of your massage sessions, please take the time to carefully complete this form. This information will be treated confidentially.

Name_____ D.O.B. _____/_____/_____ Referred by _____

Address_____ City _____ State _____ Zip _____

Occupation_____ Preferred Phone (_____)_____ □ Home □ Work □ Cell

Email Address _____

Emergency Contact _____ Phone (_____) _____

Have you had a professional massage before? □ Yes □ No

What are your goals/concerns for today's session? _____

Check any of the following that apply to you: □ Stress □Pain □Self-help □Relaxation □Other

Please state any recent or past injuries or medical treatments _____

_____

Please indicate any allergies _____

Please check the following conditions that apply or have applied to you:

□ Abdominal Hernia	□ Cold Feet/Hands	□ Heart Condition	□ Severe Depression
□ Arthritis	□ Constipation	□ Herniated Disc	□ Severe Irritability
□ Back Pain	□ Diabetes	□ High Blood Pressure	□ Shortness of Breath
□ Blood Clots	□ Diarrhea	□ Loss of Balance	□ Sinusitis
□ Broken Bones	□ Ears Ringing	□ Low Blood Pressure	□ Skin Disorders
□ Bursitis	□ Edema	□ Menstrual Pain/PMS	□ Stomach Disorders
□ Cancer	□ Fainting Spells	□ Neck Pain	□ Varicose Veins
□ Chest Pain	□ Headaches	□ Numbness: Feet/Hands	

Do you experience difficulty lying on your □ Front □ Back □ Side?

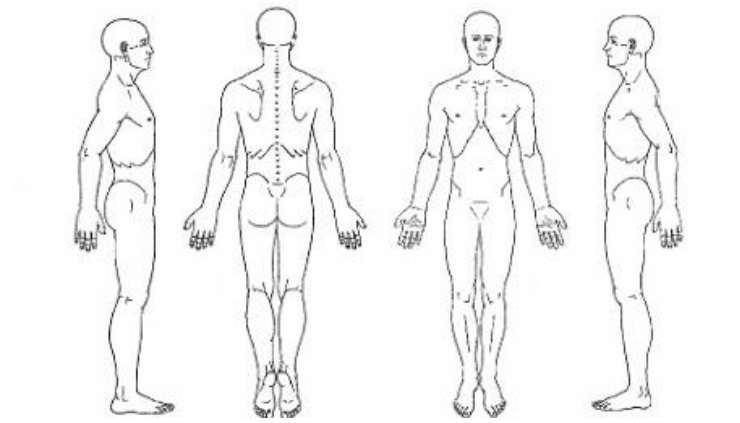
Are you under medical care or supervision now? □ Yes □ No. If yes, for what? _____

_____

Are you currently taking any medication? □ Yes □ No. If yes, what? _____

_____

Please indicate location(s) of sore or painful areas on the diagram below:



Financial Policy: We ask our clients to pay at the end of each visit, unless prior arrangements have been made.

Cancellation Policy: A 24-hour notice is required if you are unable to keep your appointment.

Etiquette: Throughout your body treatment you are discreetly covered. Inappropriate actions or language is cause for termination of treatment. We reserve the right to refuse service to anyone.

Signature_____ Date_____/_____/_____