



Valeo Massage New Patient Form

Name _____ Date of Birth _____

Street Address _____ PO Box _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Email _____

Emergency Contact _____ Phone _____

Email Address _____

Whom may we thank for referring you? _____

How did you here about our Facility? _____ Newspaper _____ Website _____ Other: _____

Please answer the following:

Have you had a professional massage before? YES NO

Do you wear contacts? YES NO

Do you have varicose veins or a history of blood clots? YES NO

Do you have blood pressure problems? YES NO

Do you have heart problems? YES NO

Do you have breathing problems or asthma? YES NO

Do you have digestive problems? YES NO

Have you suffered any serious injuries or illness
in the past six months? YES NO

Have you been hospitalized in the past year? YES NO

Are you seeing a therapist or counselor? YES NO

Please list any other health concerns or conditions that I should be aware
of: _____

WOMEN ONLY:

Do you have unusually heavy or painful menstruation? YES NO

Are you pregnant? YES NO

*****PLEASE ELABORATE ON ANY QUESTION WHICH YOU ANSWERED "YES" ON THE BACK OF THIS FORM*****

I, _____, understand that the massage therapy given is for the purpose of stress reduction, relief from muscular tension or spasm, reduction of scar tissue and chronic pain, and for the promotion of circulation, lymph activity, flexibility and energy flow. I understand that a massage therapist does not diagnose illness, disease or any other physical or mental disorder. I understand that it is my responsibility to inform the massage therapist of any existing condition.

SIGNATURE _____ DATE _____