



General Information

Last Name: _____ First Name: _____ M.I. _____ Date: _____
 Address: _____ City: _____ Zip: _____
 Phone #is: Hm. _____ - _____ - _____ Wk: _____ - _____ - _____ Mobile: _____ - _____ - _____ Sex: M F
 Birthdate: _____ Age: _____ Emergency Contact: _____ Ph. _____ - _____ - _____
 Email: (Required) _____ (We provide appointment confirmations via email)
 Occupation / Activities: _____
 How did you hear about us (Circle response or fill in)
 Website / Special Offer / Client or Patient / Other: (Fill in): _____
 Physician / Chiropractor / Other Health Professional (Name): _____

LLM Staff: Referral recorded?
 Y N

General Condition History

Place a checkmark beside the conditions you are currently experiencing:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stiff Joints |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Allergies |
| <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Swollen Feet/Legs |
| <input type="checkbox"/> Bone Fractures | <input type="checkbox"/> Eczema | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Excess Stress | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rashes | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Attack/Ailments | <input type="checkbox"/> Ringworm | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Hemophilia | | |

For Women Only:
 Pregnant (___ Weeks) Trying to get Pregnant Menopause PMS Excessive Bleeding Amenorrhea

Accident, Injury, Surgery, Medication & Miscellaneous Information

Accident or Injury (0 - 5 years ago): _____
 Accident or Injury (Over 5 years ago): _____
 Currently receiving medical or chiropractic care? Yes No. If yes, explain: _____
 Are you currently taking medications (prescription or over-the-counter)? Yes No
 If yes, explain: _____
 Are you wear contact lenses? Hard Soft Have you ever received massage before? Yes No
 What did you like/dislike about previous massage sessions:

Acknowledgements

- I acknowledge that the above information is complete and accurate to the best of my knowledge and I will notify Living Lotus Massage and/or treating LMP of any changes in my physical condition or in the information in this form prior to any additional treatment.
- I understand that appointments cancelled less than 24 hours prior to the scheduled appointment time will be subject to a charge equal to 50% of the massage service booked. Appointments not kept will be charged 100% of the massage service booked.

Client or Guardian Signature: _____
Date: _____

Mark an X where you have tension or pain.

The diagram consists of four line drawings of a human body from the waist up. From left to right: a side profile view of the left side, a front view, a back view with a dashed line down the spine, and a side profile view of the right side.