Print Name: _____

Address: _____

_____

Phone: _____

Date of Birth: _____

Are you affected by any of the following conditions? Please check appropriate box:

☐ Infectious Disease ☐ Osteoporosis
☐ Edema or Swelling ☐ Fever
☐ Inflammation ☐ High Blood Pressure
☐ Varicose Veins ☐ Cancer
☐ First Trimester of Pregnancy ☐ None

Do you have any specific areas of muscle tension?

1)_____

2)_____

FEES ARE PAYABLE AS SERVICES ARE RENDERED