660 Linton Blvd., Suite 200 EX6
Delray Beach, FL, 33444

Phone: 561-789-6869
Web: http://ADeVoeLMT.com

ADeVoe,LMT,LLC
State and Nationally Certified
Licensed Massage Therapist

CLIENT INFORMATION

Name:			Today's Date:		
Address:					
City, State, Zip:					
Daytime Phone:			Evening Phone:		
Email:			Would you like to receive emails about specials, discounts or other massage related information? ☐ Yes ☐ No		
Date of Birth:			Occupation:		
Employer:					
Referred By:					
Physician:					
Previous Experience With Massage:					
Primary Reason for Appointment / Areas of Pain or Tension:					
Please mark (X) all conditions that apply now. Put a P for past conditions.					
	headaches, migraines		chronic pain		fatigue
	vision problems, contact lenses		muscle or joint pain		tension, stress
	hearing problems, deafness		muscle, bone injuries		depression
	injuries to face or head		numbness or tingling		sleep difficulties
	sinus problems		sprains, strains		allergies, sensitivity
	dental bridges, braces, dentures		arthritis, tendonitis		rash,
	jaw pain, TMJ problems		cancer, tumors		infectious diseases
	osteoporosis		spinal column disorders		blood clots
	constipation, diarrhea		diabetes		varicose veins
	hernia		pregnancy		high / low blood pressure
	IUD birth control		heart, circulatory problems		do you bruise easily
	abdominal or digestive problems		epilepsy or seizures		other medical conditions not listed
Explain any areas noted above:					
Current Medications, including aspirin, ibuprofen, herbs, vitamins, etc:					
Surgeries:					
Accidents:					
Please list all forms and frequency of stress-reduction activities, hobbies, exercise, or sports participation:					

I understand massage should not be performed under certain medical conditions and I affirm I have stated all my known medical conditions and answered all questions honestly. I agree to keep my practitioner updated as to any changes in my medical profile and there shall be no liability on the practitioner's part should I fail to do so.

Signature: _____ Date: _____