Cecilia Mills
(814) 571-9234
calmpoint@gmail.com

Name _____ Date of Birth_____

Address _____ City/State/Zip_____

phone number _____ Cell phone _____

e-mail_____

Have you had a massage before? Yes or No

Please list illnesses, injuries or recent surgeries _____

Major area of discomfort _____

Please check if you have any of the following:

___ Back Pain/Stiffness ____Neck Pain/Stiffness _____Joint Pain

___ Knee Pain ____ Elbow Pain _____Shoulder Pain

___ Varicose Veins ____Numbness/Tingling? Where? _____

____High or Low Blood Pressure ____Skin Conditions_____

____Diabetes ____COPD/ Emphysema _____ Digestive Conditions_____

____Allergies (please list type) _____

Other_____

I have completed this form to the best of my knowledge. I understand massage is only an aid to my health and in no way takes the place of a doctor's care. I agree to update my health information as needed with each session. I will let the massage therapist know if I am uncomfortable at any time.

I understand that payment is due to the therapist at the time of the massage appointment. Cancellations within less than 24 hours of scheduled appt. are subject to a 50 % fee.
Signature_____ Date _____