Ann M. Ellis, LMT

myofascialreleasecapecod.com

508-896-3350

Name _____ Date _____

Address _____

Phone _____ Email _____

Occupation _____ Date of Birth _____

How did you hear about us? _____

Do you have any allergies? _____

Are you pregnant? ____*Yes* ____*No* Diabetes? ____*Yes* ____*No*

Arthritis? ____*Yes* ____*No* *Where?* _____

Frequent headaches? ____*Yes* ____*No* *Where?* _____

Dental work _____ Child birth _____

Please list any INJURIES or SURGERIES (this is really important - even a small scar can restrict fascial movement throughout the entire body!) _____

_____

_____

Please describe your current symptoms _____

_____

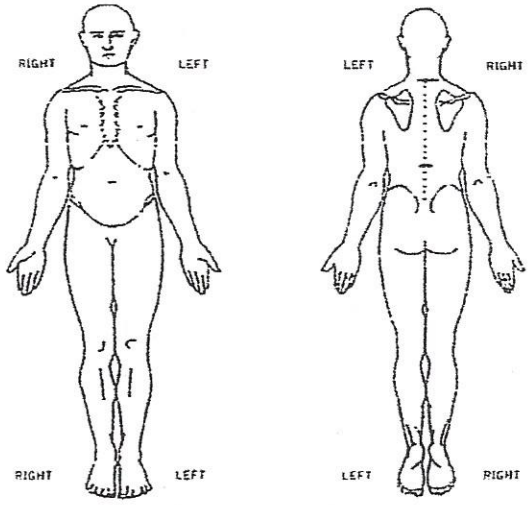
What makes it better? _____

_____

What makes it worse? _____

_____

Please mark the areas where you are experiencing symptoms:



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Please read and sign below:

I verify that all information I have provided is correct and current to the best of my knowledge. I understand that massage therapy/myofascial release involves neither diagnosis not treatment of any condition, and it is not a substitute for medical care. All information before or during this session will remain confidential. If I am uncomfortable for any reason, I may request to end the session and it will be ended.

A 24 hour cancellation is required. Without 24 hour cancellation notice I agree to pay for the missed session at the Therapist's discretion. Illness and/or medical emergencies are considered valid exceptions to the policy.

Signature _____ Date _____