Restorative Touch

104 North Main Street, Rogersville MO. 65742
417.294.2682

Date: _____

Name: _____

Address: _____

_____

Phone: _____

Occupation: _____

Birthday: _____

Email: _____

Reason for visiting today:

☐ *Relaxation* ☐ *Stress Reduction*

☐ *Muscular Soreness* *Location:* _____

Have you had a massage before: ☐ *Yes* ☐ *No*

What is your preference of pressure?

☐ *Light (1-3)* ☐ *Moderate (4-6)* ☐ *Deep (7-10)*

Are you under a physicians care? ☐ *Yes* ☐ *No*

Please list any medications you are currently taking:

_____

_____

_____

_____

_____

Other health care you are receiving:

☐ *Counseling* ☐ *Acupuncture* ☐ *Chiropractic* ☐ *Other:* _____

Can you briefly explain your medical history, including dates of surgeries, etc. ***(all information is confidential)***

_____

_____

_____

_____

_____

How would you rate your health? (1=Poor, 10=Excellent) _____

Do you mind the use of Essential Oils? ☐ *Yes* ☐ *No*

Please complete the information on the back of this page.

Please circle any health conditions that affect your life now or have in the past:

Abdominal Pain
Abnormal Periods
AIDS
Allergies
Anemia
Aneurysm
Asthma
Back or Neck Pain
Bloating
Breast Implants
Cancer
Chest Pain
Chronic Bronchitis
Chronic Colds
Chronic Constipation
Chronic Cough
Chronic Sore Throat
Cirrhosis
Colitits/Irritable Bowel
Congestive Heart Failure
Dental Problems
Diabetes: Type 1
Type 2
Eczema
Edema
Emphysema
Family or Relationship Stress
Fatigue (Chronic or Excessive)
Fibromyalgia
Gout
Headaches
Hernia
Hypoglycemia
High Blood Pressure
HIV
Intestinal Problems
Kidney/Bladder Problems
Liver Problems
Low Back Pain
Multiple Sclerosis
Migraine Headaches
Musculo-skeletal Injuries
Pacemaker
Phlebitis
PMS
Pre-menstrual Headache
Pneumonia (recurring)
Psoriasis
Pulmonary Edema
Sinusitis
Skin Problems
Stroke
Surgeries
Tuberculosis
Thyroid: High
Low
Ulcers
Varicose Veins
Work Stress
Other:

- **I understand that I can terminate the massage at anytime I choose.**
- **I understand that any attempt to sexualize the massage will be cause for termination of the massage by the therapist.**
- **I understand that this massage is not a substitute for medical treatment and that no diagnosis or prescription is made or inferred.**
- **I understand that if I do not cancel an appointment 24 hours in advance, I will be charged the full fee.**

Signature **Date**