

Print Name: _____

Do you have any specific areas of muscle tension?

Address: _____

1) _____

2) _____

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

FEES ARE PAYABLE AS SERVICES ARE RENDERED