L.J. Yoder, CMT, PDMT
612 S. Michigan Ave. Marion, IN 46953
(765) 661-0238

Please Print

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell # : _____

May I Text You? _____ Work # : _____ Email address: _____

Employer: _____ Address: _____

Profession or Occupation: _____

Date of Birth: _____ SS# : _____

Is this your first Professional Massage? _____ If no, How frequently do you get a Massage? _____

* * * *

PLEASE PRINT

1. Have you had any injuries to your spine? _____ If yes, please explain. _____

   Date/Type of Surgery: _____

2. Have you had any surgeries in the past year? _____If yes, please explain.

   Date/Type of Surgery: _____

3. Have you had, or do you have, any blood clots or tumors that you are aware of? _____

   If yes, please explain. Date/Type of Surgery: _____

4. Do you have any medical condition that I should be made aware of before giving you Massage Therapy? _____

   If yes, please explain. _____

5. Have you talked to your doctor about the advisability of having Massage Therapy? _____

6. If a medical emergency should arise during your massage therapy session, who should I contact?
   Name: _____ Relationship? _____

   Telephone Number: _____

6. Are you now taking any prescription drugs? _____If so, please describe.

Medication: _____Condition: _____

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Medication: _____Condition: _____

Medication: _____Condition: _____

Medication: _____Condition: _____

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