BETH LEAVITT, CMT

Client Information Sheet

Personal Information

Name: _____ Phone(h)_____(w)_____

Address:_____ City_____St.____zip____

Occupation: _____ DOB: _____

How were you referred? _____

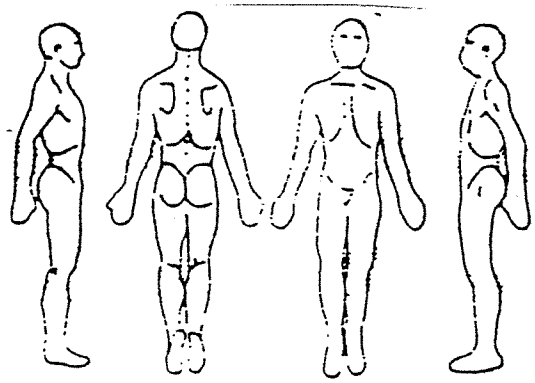
Have you ever received a Massage before today? _____

General Medical Information

Have you ever suffered from.....

( )	Arthritis	( )	High Blood Pressure	( )	Stiff Neck
( )	Bursitis	( )	Low Blood Pressure	( )	Hematomas
( )	Low Back Pain	( )	Poor Circulation	( )	Phlebitis
( )	Neck Pain	( )	Anemia	( )	Pregnant
( )	Fatigue	( )	Stroke	( )	Other (explain)
( )	Sciatica	( )	Chest Pain		_____
( )	Spinal Curvature	( )	Cancer		_____
( )	Swollen Joints	( )	Varicose Veins		_____
					_____

Draw Your Symptoms



I understand that massage therapy bodywork is not a substitute for medical care and that any information provided to me by the therapist is not diagnostically prescriptive but is for educational purposes only. I will, as much as possible, participate in my own healing.

_____ _____

client signature date

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