Robert Jordan, LMT298

1707 South Colorado Street, Suite A
Greenville, MS 38703

Name:_____ Date:_____

Address:_____

City State Zip

Date of Birth:_____ Occupation:_____

Phone (for appointment reminders):_____ Phone (Other):_____

Email Address:_____

Who to notify in case of emergency:_____

Name Number

General Medical History/Information

YES NO (If you answer yes to any of the following, please explain in the space below or on the back of this sheet.)

_____ _____ Have you ever had a professional massage?_____

_____ _____ Are you pregnant?_____

_____ _____ Are you wearing contact lenses?_____

_____ _____ Are you diabetic?_____

_____ _____ Do you have epilepsy or have seizures?_____

_____ _____ Do you have high blood pressure?_____

_____ _____ Have you ever had blood clots?_____

_____ _____ Do you now or have you ever had any spinal problems?_____

_____ _____ Do you now or have you ever had any heart/cardiac problems?_____

_____ _____ Have you ever had surgery?_____

_____ _____ Have you had any broken bones, serious illness or injuries in the past two years?_____

_____ _____ Are you suffering from any chronic illness or pain?_____

_____ _____ Do you have any skin conditions?_____

_____ _____ Do you have any other health problems or concerns not already listed?_____

Medications:_____

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment.

Signed:_____ Date:_____