



Cat Paws Massage

Name _____ Employer _____
 Address _____ Position _____
 City, State, Zip _____ Work Phone _____
 Home & Cell Phones _____
 Email _____ Birthdate _____

How were you referred to Cat Paws? _____

Please circle any symptoms that you have or had in the past regarding these conditions:

- | | | | | | |
|-----------------------------|-----------------------|----------------------|------------------|------------------|-----------------------|
| <i>Recent Injuries</i> | <i>Joints/Muscles</i> | <i>Digestion</i> | <i>Cancer</i> | <i>Sleep</i> | <i>Allergies</i> |
| <i>Heart/Blood Pressure</i> | <i>Bones</i> | <i>Mental Health</i> | <i>Diabetes</i> | <i>Surgeries</i> | <i>Cold. Flu</i> |
| <i>Lungs/Breathing</i> | <i>Reproduction</i> | <i>Autoimmune</i> | <i>Headaches</i> | <i>Skin</i> | <i>Sensory Organs</i> |

Please describe these in detail, including **medications** taken and **caffeine** consumed:

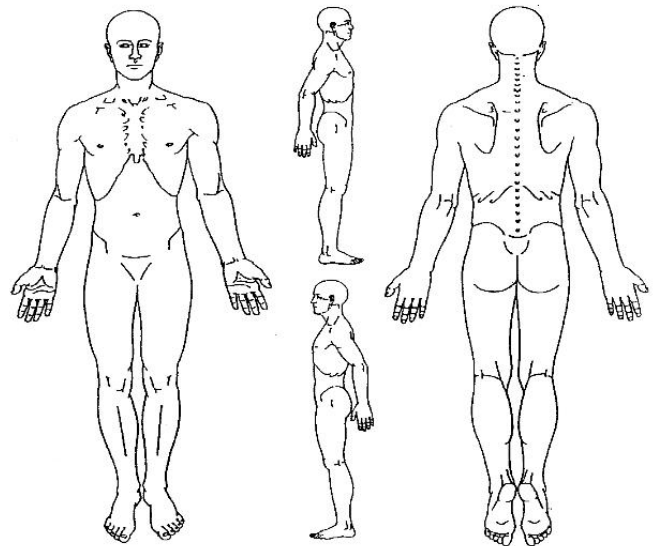
Physician /Health Provider: _____
 Emergency Contact: _____

Please fill in location of any pains on model:

CONSENT FOR BODYWORK:

By signature, I agree:

- 1) I have fully disclosed my health history and will inform LMT of any changes.
- 2) Behavior of a sexual nature is not tolerated and will result in termination of massage with full payment due. _____ INITIAL
- 3) Payment is due at time of service. If L&I or insurance rejects claim, I understand I am liable for payments due.
- 4) I do not expect a reminder call of my appointments unless I request one.



Signature _____ Date _____

Thank you for your business!