LINDSEY GODSMARK, L.M.T.
LICENSED MASSAGE THERAPIST
GODSMARKLMT@YAHOO.COM
443-345-0468

Name: _____ Date: _____

Phone: _____ Email: _____

Do you have any of the following?

Allergies?:	Y/N	To What?	_____
Skin Conditions?:	Y/N	What Kind?	_____
Kidney Conditions?:	Y/N	What Kind?	_____
Heart Conditions?:	Y/N	What Kind?	_____
Cancer?:	Y/N	Where?	_____
Herniated Discs?:	Y/N	Where?	_____
Other Spinal Conditions?:	Y/N	What Kind?	_____
Diabetes?:	Y/N		

Any other information I should know?

_____

_____

_____

I hereby state that all information provided is correct according to my current state of health.
I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
I understand the benefits and risks of Massage Therapy and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.
I am responsible for all charges for all services provided, unless another agreement was made.

Sign: _____

Date: _____