ACUPUNCTUREFIT™
fit for life

PERSONAL INFORMATION

Name_____ Date of Birth _____

Phone _____ Email _____

Address _____

Occupation _____ Emergency Contact _____

What type of activity/exercise do you do? _____ How often? _____

What are your movement/health goals? _____

_____

HEALTH HISTORY

Please indicate any of the following that apply to you:

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains
- ☐ Pregnant
- ☐ Chronic Pain
- ☐ Orthopedic injuries
- ☐ Surgeries

Please explain any that you have marked above _____

_____

_____

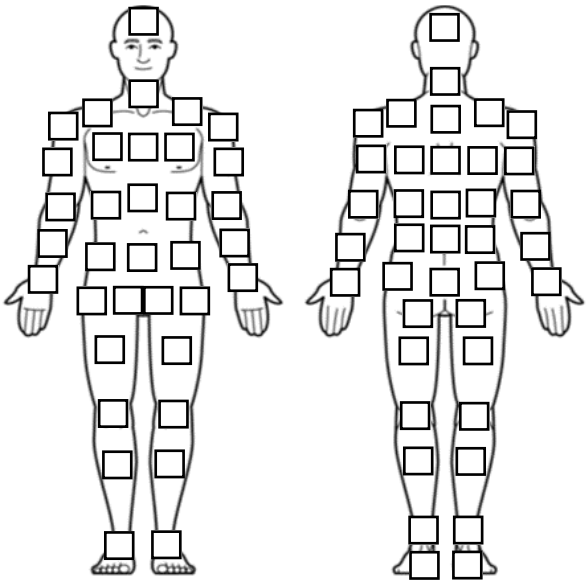
What medications/supplements are you currently taking?

_____

_____

Any allergies or sensitivities? _____

Circle areas of discomfort:



MASSAGE INFORMATION

Have you received Therapeutic Massage or Stretch Therapy before? _____

What is your goal for your massage treatments? _____

_____

Are there any areas you do not want massaged? _____

CLIENT SIGNATURE _____ DATE _____

THERAPIST SIGNATURE _____ DATE _____