KLYNERGY
MASSAGE & WELLNESS

3102 W. Euclid Ave
Tampa, Florida 33629
Phone: 813-304- 2105
E-Mail: info@KLynergyWellness.com
Web: www.KLynergyWellness.com

Name:		DOB (mm/dd/yy):	
Address:		City/Zip:	
Phone:		Referred by:	
Physician:		Occupation:	
Reason for visit:		Company:	
Email:		Join our mailing list?	Yes No
1st massage ever?	Yes No	Join our social media?	Yes No

Health History

To help understand your health status, please accurately check all that apply. All information disclosed is confidential.

Musculoskeletal

	Bone/Joint disease		Back, Hip, Leg Pain		Cramps/ Spasms
	Tendonitis/Bursitis		Neck/Shoulder Pain		Arthritis
	Disc Problems		Headache/Migraines		Sprains/Strains
	Fractured Bones		Jaw Pain/ TMJ		Pins/Plates
	Pins/Plates		Numbness/Tingling		Other

Other:

Circulatory

	Cardiac Conditions		Bruise easily		Stroke
	Varicose Veins		High Blood Pressure		Thrombosis
	Blood Clots		Low Blood Pressure		Lymph Edema

Other:

Respiratory

	Breathing Difficulty		Sinus Problems		Emphysema
	Allergies_____		Tuberculosis		Pneumonia
	Asthma		Bronchitis		Lung Cancer

Other:

Integumentary

	Sensitive Skin		Rashes		Bug Bites
	Eczema		Athletes Foot		Warts

Other:

Reproductive

	Pregnant (Trimester)_____		Hormonal Treatment (type?)		Breast Augmentation
	Hysterectomy		Fertility treatments		Enlarged Prostate

Other:

Other Conditions

	Cancer/Tumors_____		Diabetes _____		Depression
	Autoimmune_____		Thyroid_____		Contact Lenses
	Endocrine_____		Multiple Sclerosis		Hernia

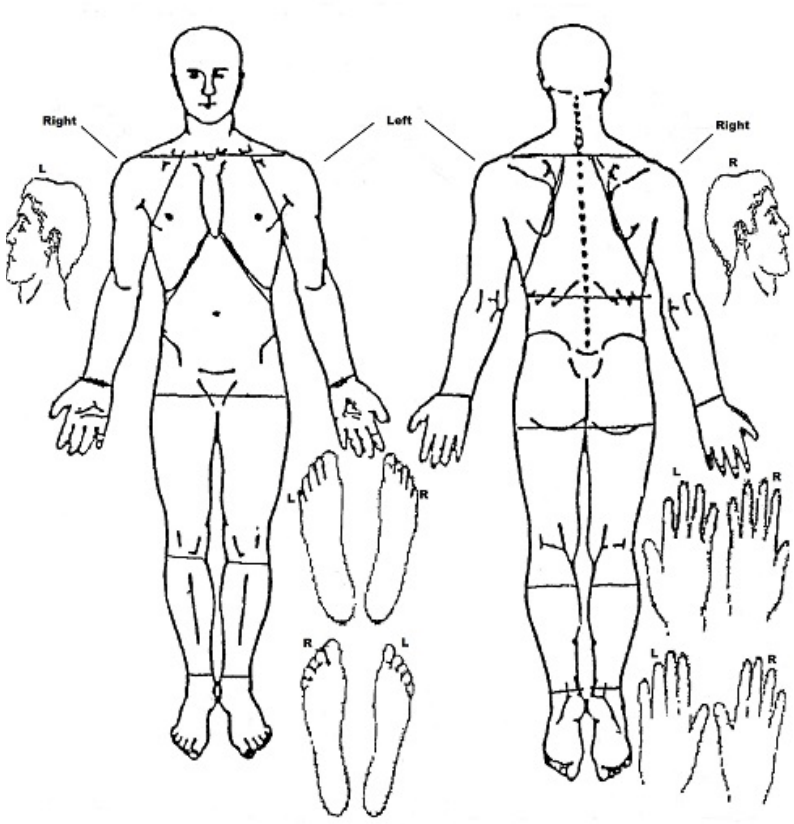
Other:

Please check and list any medications you are currently taking for the following

	High/Low Blood Pressure		Birth Control		Cholesterol
	Mood Balancing		Seizures		Muscle Relaxer
	Pain		Performance Enhancement		Extracurricular

List:

Please mark where you are experiencing pain or where you hold tension. Please rate your present pain on a scale from 1-10 ____.



Please list any other conditions, syndromes, accidents, or surgeries pertinent to your health:

Notes/Comments:

Cancellation or No Show Policy

By signing you agree to the following: You will give KLynergy Massage & Wellness 24hrs notice to avoid a late cancellation fee of $25. If we do not receive a cancellation notice, or a valid reason for not showing for your appointment, we reserve the right to charge you full price for the missed appointment.

Signature:_____ Date:_____

For a Minor Under 18 years of age

I _____ have given consent for my child to receive Massage or other modalities.

Legal Guardian Signature:_____ Date:_____

Please Read and Sign

It is my choice to receive Massage Therapy. I realize treatment is given for the well being of my body and mind; This includes stress reduction, relief or reduction of muscular tension, spasm or pain, increase circulation and/or energy flow. All information regarding my health has been accurately disclosed and I understand the information is confidential with-in this institution. I will notify my Therapist of any changes in my health. I understand that Massage Therapists do not diagnose illness, disease, or any physical or medical disorder; nor prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that Massage Therapy is not a substitute for medical examination, diagnosis, or treatment, if those services are needed or recommended I will see my Primary Healthcare Provider. Lastly I agree to notify the Massage Therapist if I am not comfortable with the treatment being provided. I respect the rights of the Massage Therapist discontinue or deny treatment.

Signature:_____ Date:_____