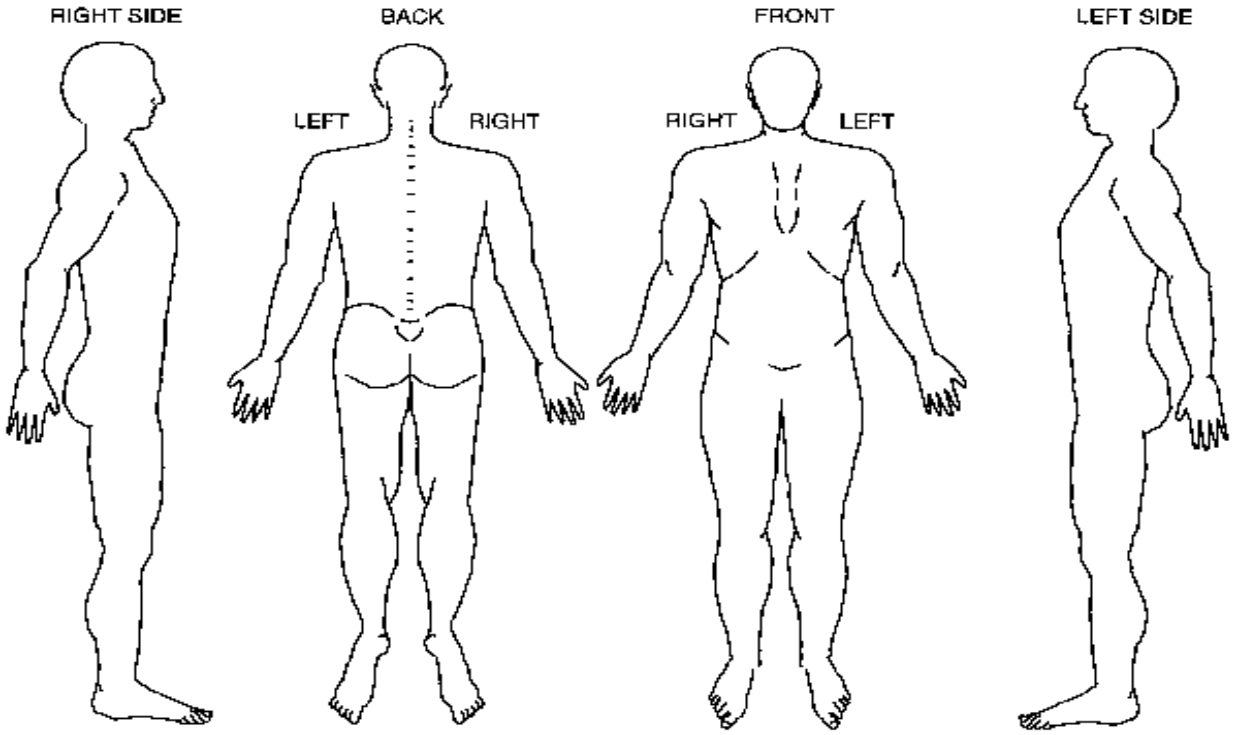
Wellness Roots Massage Intake

Patient Name: _____Date:_____

Please indicate below where you experience any pain or muscle tension/stiffness:



Please list trauma's: (sprains, strains, fractures, etc.)

_____

_____

_____

Please list surgery's:

_____

_____

Do you have any allergies?

_____

Do you have any other health concerns/issues?

_____

_____

Are you on any blood thinners: (circle) YES NO