Name _____

Mailing address. _____ Postal code _____

Phone no. (Home) _____ (Work) _____

Email. _____

Occupation (optional) _____

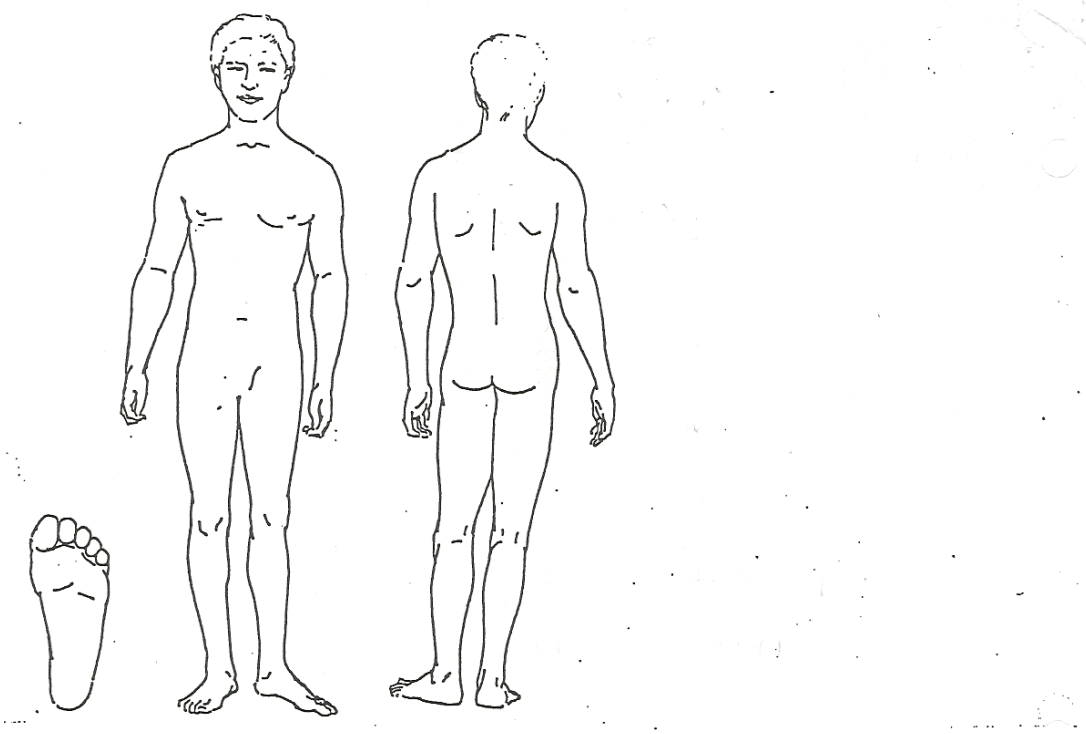
Age (optional) _____

Please tick, if you experience any of the following:

Headaches	Migraines	Trouble sleeping	Re-occurring Injury	
Back Pain	Numbness	Tingling	Neck Pain	
Aching	Digestive Problems	Poor circulation	Nausea	
Epilepsy	Heart disease	High/ Low blood pressure		
AIDS/HIV	Hepatitis C	Asthma	Eczema	Psoriasis

Are you currently taking any medication or pills? _____

Please indicate any areas of tension, pain, injuries or surgery.



I understand any information given on this form or in a treatment session is confidential and will not be disclosed without permission.

I will give at least **24 hours notice if I wish to cancel an appointment, and otherwise pay the full session fee.**

Signed

Date / /

_____ _____