

# CUSTOMER INFORMATION FORM

First name \* \_\_\_\_\_ Family name \* \_\_\_\_\_  
Social security number \* \_\_\_\_\_ Municipality of residence\* \_\_\_\_\_  
Telephone \_\_\_\_\_ Profession \_\_\_\_\_  
E-mail \_\_\_\_\_  
Address \_\_\_\_\_  
Postal code \_\_\_\_\_ City \_\_\_\_\_

\* Decree of the Ministry of Social Affairs and Health on medical records (298/2009, 10 §)

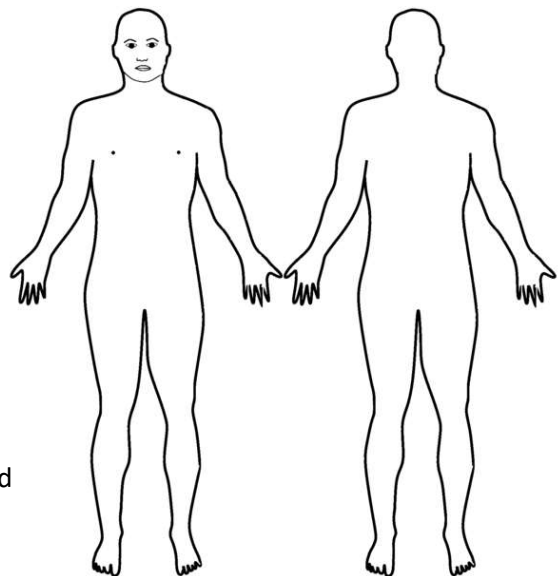
The cause of the massage:

\_\_\_\_\_  
\_\_\_\_\_

Diseases (Use additional information field if needed)

- Asthma
- Diabetes
- Epilepsy
- HIV / AIDS
- Venous thrombosis
- Osteoarthritis
- Osteoporosis
- Rheumatism
- Heart disease
- Cancer
- Blood pressure
- Haemophilia
  
- Something else, please, use additional information field

Mark your painful areas



Additional information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant:  Yes /  No

Exercise and hobbies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My contact information may be used for after-sales services. The contact information will not be disclosed to third parties.

Date \_\_\_\_ . \_\_\_\_ . 20\_\_\_\_ Signature \_\_\_\_\_