Referred by _____

PERSONAL HEALTH HISTORY

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK PHONE: _____ OCCUPATION: _____

MARITAL STATUS: ___ FAMILY DOCTOR: _____ CHIROPRACTOR: _____

ARE YOU PRESENTLY SEEING A:
PSYCHIATRIST _____ PSYCHOLOGIST _____ PHYSIOTHERAPIST _____ OTHER _____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD ISSUES WITH IN THE PAST:

Allergies ___	Cancer ___	Head Aches ___	Liver Disease ___	Shoulder Pain ___
Addictions ___	Diabetes ___	Heart Disease ___	Migraines ___	Skin Problems ___
Back pain ___	Nausea ___	High Blood Pressure ___	Ulcers ___	Dizziness ___
Hip pain ___	Neck pain ___	Digestive Problems ___	Kidney Disease ___	Arthritis ___
Epilepsy ___	STD ___	Bruise Easily ___	Bowel Disorder ___	Bursitis ___

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING:

_____

_____

PLEASE LIST ANY SURGERIES YOU HAVE HAD:

_____

_____

WOMEN ONLY:
Are you currently pregnant? _____
Do you suffer from menstrual cramping? _____

PLEASE LIST ANY OTHER TRAUMA, ABUSE, ILLNESS, OR ACCIDENTS NOT NOTED IN ANY OF THE ABOVE:

_____

_____

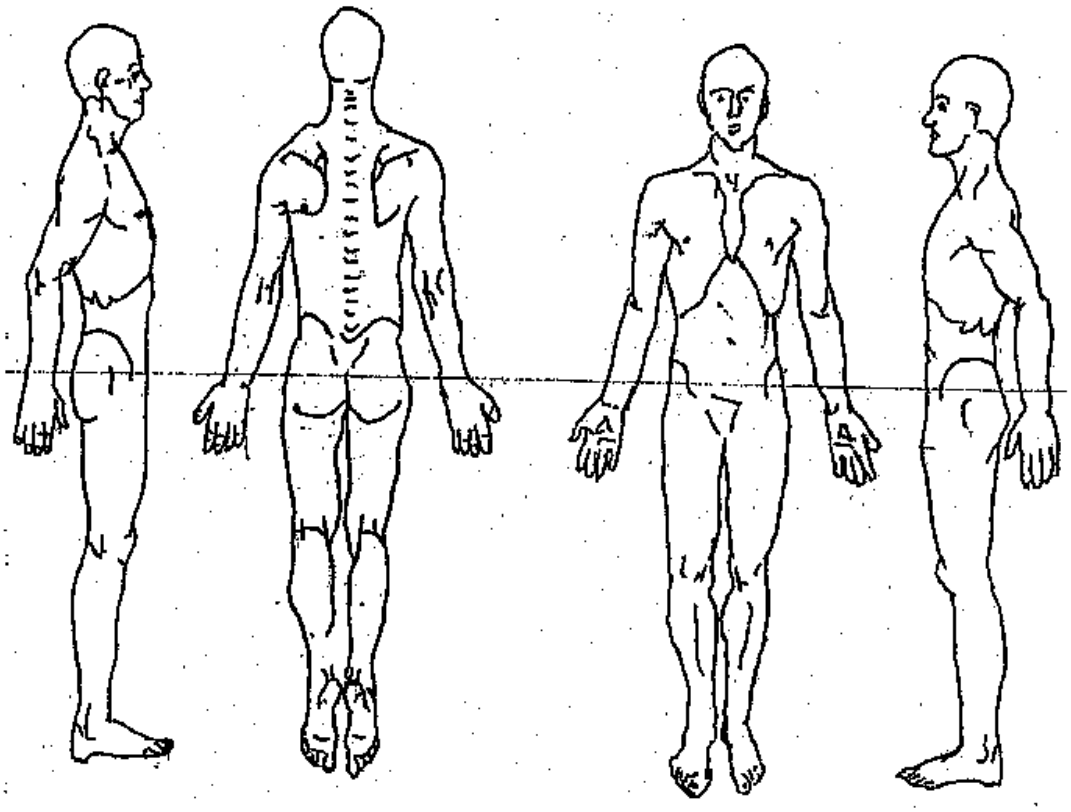
PLEASE INDICATE REASON OR BENEFITS YOU WISH TO RECEIVE FROM MASSAGE THERAPY:

_____

_____

next page please

ON THE PICTURES BELOW PLEASE CIRCLE THE AREAS THAT ARE BOTHERING YOU OR HAVE GIVEN YOU PROBLEMS IN THE PAST.



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I, the undersigned, hereby certify that the above information on this form is accurate and up-to-date, and I hereby agree that it is my responsibility to keep my therapist properly informed of any changes in my state of health.

DATE: _____ SIGNATURE: _____

FEES ARE TO BE PAID AT THE TIME THERAPY IS RENDERED.