HEALTH SURVEY

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any of the following symptoms you have experienced in the past 6 months.

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| 1. Low Back Pain | 11. Shoulder Pain | 21. Wrist / Carpal Tunnel  |
| 2. Neck Pain | 12. Hip Pain | 22. Arthritis |
| 3. Pain Between Shoulder Blades | 13. “Pinched Nerve” | 23. Rotator Cuff  |
| 4. Auto Accident (last 3 months) | 14. Tension Across the Top of Shoulders | 24. TMJ (clicking or painful jaw) |
| 5. Tension / Headaches | 15. Tingling/Numbness in Arms or Hands | 25. Fibromyalgia |
| 6. Migraines | 16. Tingling/Numbness in Legs or Feet | 26. Allergies |
| 7. Mid Back Pain | 17. Foot Pain / Plantar Fasciitis | 27. Food Intolerance |
| 8. Pulled Muscles | 18. Tennis Elbow/Golfer’s Elbow | 28. Asthma |
| 9. Scoliosis | 19. Hand Pain | 29. Chronic Fatigue |
| 10. Knee Pain | 20. Hamstring Pull | 30. Abdominal Cramping |

Which of the above symptoms is the worst? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long have you had it? \_\_\_\_\_\_\_\_\_\_\_\_

**WOULD YOU LIKE TO GET RID OF THE PROBLEM? □ YES □ NO**

Do you have insurance? □ YES □ NO

**Females: Are you pregnant? Y N**

**Do You Have An Interest in ANY of the Following?**

**Weight Loss \_\_\_\_ Hormone Replacement Therapy \_\_\_\_\_ Allergy Treatment \_\_\_\_**

**Consent/Waiver of Liability:** I consent to a chair massage provided by an independent massage therapist. I hold Phoenix Valley Health Partners harmless and agree that there shall be no liability on the part of PVHP in any way related to the chair massage.

SIGN HERE

*For office use only*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_

Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rep. INT: \_\_\_\_\_\_\_Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_