Health Profile Form

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This information will be treated confidentially.

Name

First

Last

Address

Address Line 1

Address Line 2

City

State

Zip Code

Phone

Email

Date of Birth

Referred By

What Is Our Goal For Treatment?

Are You Experiencing Discomforts?

If So, Where?

Medical History – Please Check Those That Apply

☐ Hypertension
☐ Heart Disease
☐ Arteriosclerosis
☐ Varicose Veins
☐ Phlebitis
☐ Fluid Retention
☐ Epilepsy
☐ Herpes I or II
☐ Mental Illness
☐ Osteoporosis
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Fibroids
☐ Fibromyalgia
☐ Headaches
☐ HIV Positive
☐ Pregnant
☐ Easy Bruising
☐ Chronic Fatigue Syndrome
☐ Cancer/Malignancy
☐ Fractures
☐ Abscess or Open Sores
☐ Herniated Disc
☐ Joint Replacement

Any Accidents or Surgeries?

Medications Currently Taking and the Reason Why

It is understood that this work does not constitute medical treatment. I take responsibility for alerting my practitioner to any physical conditions that would affect this work. I will not hold the practitioner liable for the treatment received.

FULL SESSION FEES WILL BE CHARGED FOR MISSED OR CANCELED APPOINTMENTS WITH LESS THAN 48 HOURS NOTICE.

COVID & FLU: If you are scheduled to see me and have come down with flu-like symptoms, please notify me as soon as possible - I will discuss with you options to reschedule and will work with you on a case by case basis.

Signature - By Entering Your Name You Are Electronically Signing this Document

Enter Full Name