Medical History

Date_____

Name_____ Phone # (Home)_____

Address_____ Cell #_____

_____ Work #_____

Occupation_____ E-mail_____

Referred by_____ Birth date_____

Are you currently being treated by a doctor, chiropractor or other practitioner? Yes_____ No_____

If Yes, Why?_____

Physician's name, address & phone #:_____

_____

Please check all that apply:

___Abdominal Problems	___Allergies	___Arthritis	___Asthma
___Ankle Problems	___Back Pain	___Bed Wetting	___Bone Spurs
___Breast Lumps	___Breast Pain	___Breast Implants	___Bronchitis
___Bunions	___Bursitis	___Buttock Pain	___Cancer
___Carpal Tunnel	___Chest Pain	___Colic	___Constipation
___Diaphragm Pain	___Depression	___Dislocated Joints	___Dizziness
___Digestive Problems	___Diabetes	___Ear Problems	___Edema
___Fatigue (Chronic)	___Fibromyalgia	___Fracture (Old/New)	___Hay Fever
___Gallbladder Problems	___Hamstring Problems	___Headaches	___Heart Problems
___Hernia	___Hip Pain	___Hip Replacement	___Hypertension
___Hypotension	___Incontinence	___Infertility	___Joint Replacement
___Jaw & TMJ problems	___Liver Problems	___Lung Problems	___Migraines
___Knee Problems	___Neck Pain	___Numbness	___Orthodontia
___Osteoporosis	___Pain (Mark on back)	___Pelvic Problems	___Phlebitis
___Plantar Fascitis	___Pregnant	___Prostrate Problems	___Rib Problems
___Seizures	___Sacral Problems	___Sciatica	___Scoliosis
___Shin Splints	___Skin Problems	___Shoulder Problems	___Sinus Problems
___Tennis Elbow	___Tinnitus	___Wrist Pain	

Contagious Disease_____

Please list all accidents, injuries, surgeries and falls that you can remember. Please be detailed.

List current medications, if any (include aspirin, ibuprofen, etc.):

List current therapies:

List stress reduction and exercise activities. Include frequency.

Please describe your sleeping position, including the use of pillows and type of bed.

Have you ever had a Therapeutic Massage? Yes__ No__

Have you ever had Bowenwork? Yes__ No__

Location of Pain: Please circle any areas of discomfort on the anatomical drawings below and indicate range of pain on a scale of 1-10.

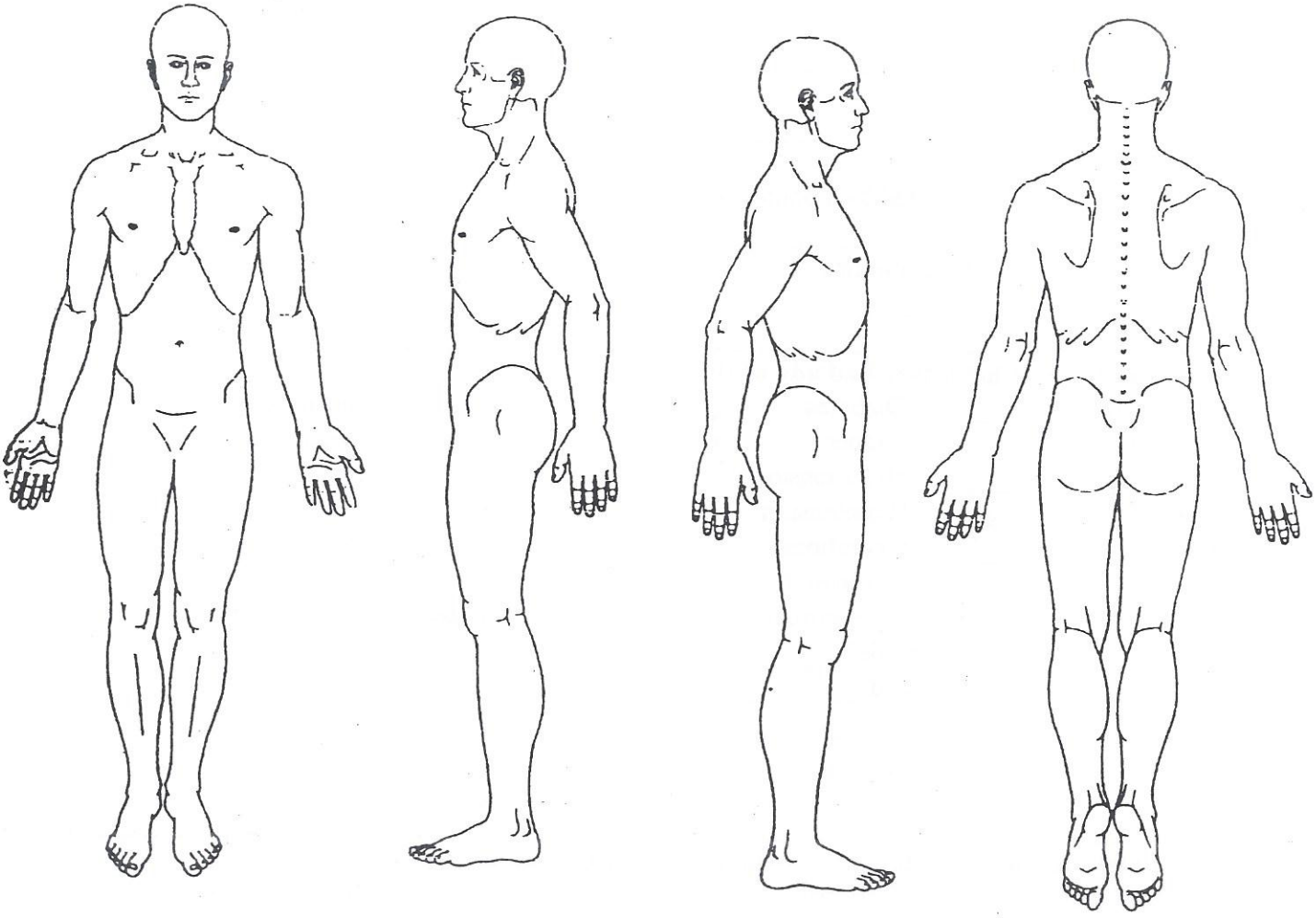
2 Mild pain (annoying, nagging)

4 Discomforting (troublesome, numbing

6 Distressing (miserable, agonizing, gnawing)

8 Intense (cramping, dreadful, horrible)

10 Excruciating (tearing, crushing, unbearable)



I understand that this session is strictly therapeutic and that a Massage and Bowen Therapist neither diagnoses illness, disease or any other medical, physical or mental disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I may have. I hereby state that I do not have any communicable diseases. All the information on this form and any shared during our sessions shall remain confidential. From time to time it may be useful to consult with your other health care provider. May I have your permission to do so: Please initial if Yes_____ No_____. I also understand that the cancellation policy is 24 hours notice excepting emergencies.

Signature _____ Date _____