



Health Information Form
A Licensed Health Care Provider

24-Hour Cancellation Policy:

All cancellations and no-shows will be billed at current rates if not notified within 24 hours. I agree to these terms and understand my account will be billed under the conditions stated.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ In case of emergency contact: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_ Newspaper \_\_\_ Yellow Pages \_\_\_ Magazine \_\_\_ Referral -Who \_\_\_\_\_

CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU

- Acne, AIDS (HIV), Allergies, Arthritis, Athlete's Foot, Cancer or Tumors, Contact Lenses, Diabetes, Eczema, Fractures, Glaucoma, Heart Disease, Herpes, High Blood Pressure, Hives or Shingles, Impetigo, Instrumentation, Joint/Back Problems, Kidney Disease, Lung Disease, Neurological Disorders, Pregnancy (currently) Term: 1 2 3, Rashes, Stroke, Thyroid Disorders, Varicose Veins, Other

The physical condition that concerns you:

\_\_\_ Fibromyalgia \_\_\_ Headaches \_\_\_ Carpal Tunnel \_\_\_ Chronic Pain

Are you taking medication or supplements presently? \_\_\_ Yes \_\_\_ No

If yes, please describe the medication/supplements: \_\_\_\_\_

Have you had a major surgical injury or procedure? Yes No \_\_\_\_\_

Is the injury related to work or auto accident? \_\_\_\_\_ Yes \_\_\_\_\_ No. Date of injury: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Are you currently making routine visits to a physician, chiropractor, psychologist, or physical therapist for an ongoing problem? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

Is stress affecting your health and wellness? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

Please circle the number which best describes your current level of stress:

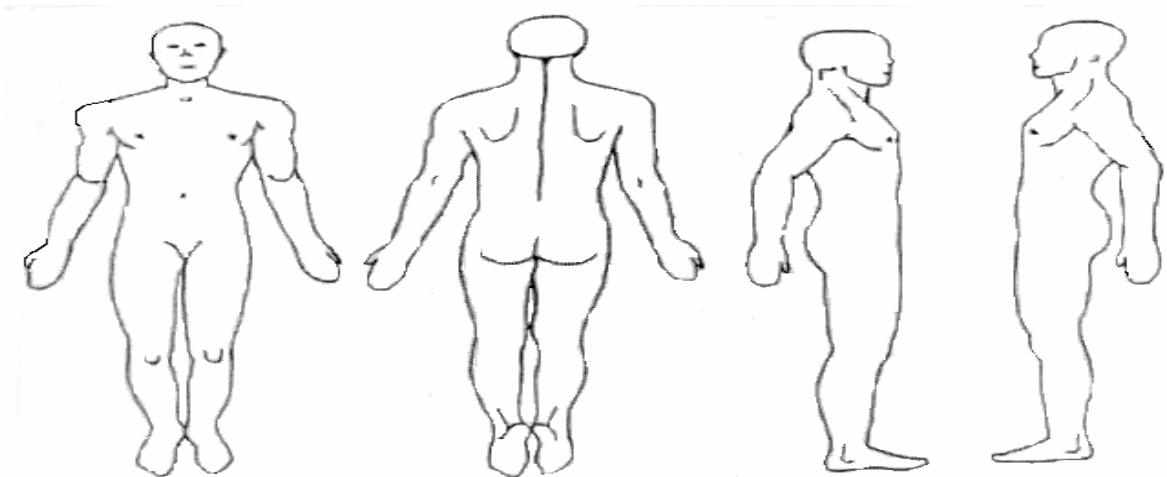
(Low) 0 1 2 3 4 5 (High)

Please circle the number which best describes your current level of health:

(Poor) 0 1 2 3 4 5 (Excellent)

What types of exercise do you engage in regularly? \_\_\_\_\_

Please indicate your concern in specific body areas with the following indications: N – numbness, T – tingling, ST – stiffness, A – ache, P – pain. Other Conditions: \_\_\_\_\_



What is your chief complaint? \_\_\_\_\_

I understand that health care services are offered at the massage clinics by a licensed practitioner, but are no way practiced or prescribed by massage therapists including the practice of medicine. Client records and transactions with the practitioner are confidential.

Payment is due upon completion of the therapeutic massage. Please make checks payable to: **PFS or Personal Fitness Systems, Inc.** Thank you.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_