Health Information Form

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: _____________________

A Licensed Health Care Provider

Name: ____ Date of Birth: _____________________

Address: ____

City: ________________State: _______________________ Zip: _______________

Employer/Occupation: ________________________Home Phone: __________________________

Client E-mail: ____

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

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Is stress affecting your health and wellness? ____ Yes ____ No

If yes, please describe: ____

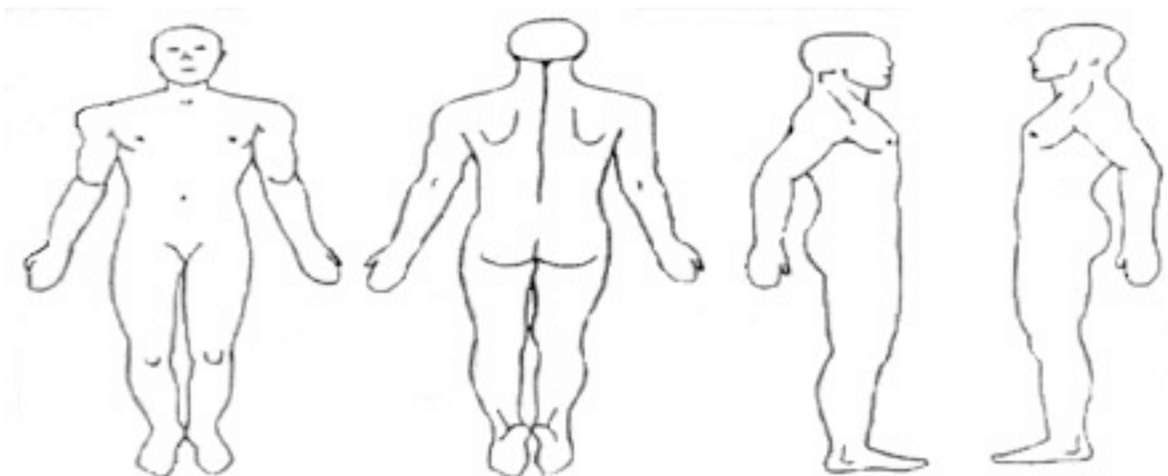
Please circle the number which best describes your current level of stress:

(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? ____



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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 practicioner, 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: _____________________