Confidential Health Information

Name: _____ DOB: _____ Age:_____

Address: _____ Phone: _____

_____ Email: _____

Doctor& Phone #: _____ Occupation: _____

Personal Trainer (if applicable) _____

For increased effectiveness, are you agreeable for clinical information to be shared with your trainer/ doctor?
YES NO

Purpose of Visit

___ Increase joint flexibility and range of motion
___ Enhance athletic performance
___ Rehabilitate from injury or surgery
___ Eliminate pain
___ Decrease mental stress
___ Preventative health care/ maintenance
___ Increase well-being
___ Other _____

General Medical Information

Please check any of the following conditions that apply to you:

___allergies
___arthritis
___asthma
___cancer
___corrective lenses (eyes)
___depression
___diabetes
___epilepsy
___fractures (bone)
___headaches
___heart disease
___high blood pressure
___HIV/ AIDS
___pregnancy
___recent surgery
___spinal issues (i.e. disc protrusion, scoliosis)
___stroke/ arteriosclerosis
___stress
___trauma
___varicose veins/ blood clots

Do you have any other medical conditions we should be aware of? _____
Please list any medications, frequency of intake, and reasons for taking them:

_____

_____

Are you sensitive to touch/ pressure in any area? _____

Requests/ Comments:

_____

_____

_____