HEALTH INFORMATION

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FIRST NAME:_____ LAST NAME:_____

ADDRESS:_____ EMAIL:_____

PHONE NUMBER: _____HEIGHT: ____WEIGHT____SEX (M)__ (F)___
MARITAL STATUS (M)___ (S)___ (D)___

EMERGENCY CONTACT_____PHONE_____

CONDITION(S) NEEDING TREATMENT

_____

_____

_____

Respiratory ( ) Digestive ( ) Musculo-Skeletal ( ) Neurological ( ) Emotional ( ) Acute ( ) Chronic ( )

ARE YOU BEING TREATED ELSEWHERE?_____

RECENT INJURIES? (List location & date)_____

_____

RECENT SURGERIES?_____

_____

OTHER BODYWORK RECEIVED?

_____

_____

PRIMARY PHYSICIAN_____

ARE YOU TAKING ANY PRESCRIPTION DRUGS (for what)_____

OTHER DOCTORS _____PHONE_____

OTHER THERAPISTS_____PHONE_____

WHO REFERRED YOU HERE? _____

This is confidential information, protected by HIPPA law. It can only be shared with your physician or psychotherapist with your permission. Sign: _____date_____

Payment is expected at the time of service. This office does not bill. Credit cards, cash or checks accepted. A super bill can be supplied upon request for insurance reimbursement.