Quintessential Massage & Wellness
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***MEDICAL HISTORY DISCLOSURE FORM* (Confidential)**

In order to maximize the effectiveness and safety of our sessions together, I ask that you take the time to fill out this confidential questionnaire carefully.

Name_____ Date _____

Street Address_____City/Town_____

State_____ Zipcode_____ (Work#)_____

(Home#)_____ (Cell #)_____

Email Address: _____

Date of Birth_____ Occupation_____

Referred by_____

What areas of the body (i.e. neck, left hip, right shoulder, etc.) or conditions (i.e. Fatigue, Arthritis, etc) are you currently seeking care for?

_____

_____

_____

_____Previous surgery - Type of Surgery _____Date_____

_____

_____

Additional Surgeries _____Date_____

_____Date_____

_____Accidents - Type of Accident _____Date_____

Additional Accidents_____Date_____

_____Date_____

If there are multiple areas of involvement, which region/problem is of greatest concern at this time? _____

_____

Have you ever been treated for this same problem before? If so, when & who treated this? _____

Did prior treatment successfully manage or resolve the problem at that time?

MEDICAL HISTORY: Please indicate below the significant medical problems, as such conditions can influence the type and/or depth of work done in any given area. Thank you. **Please circle**.

_____ Skin condition - acne, rash, allergies, skin cancer, psoriasis, eczema

_____ Lymphatic condition - swollen glands, lymphoma, lymphedema, other _____Have you had any lymph nodes taken out? _____yes _____no

_____ Circulatory condition - heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis, cardiovascular disease, high blood pressure, stroke or heart attack, other _____

_____ Neurological condition - sciatica, numbness/tingling of any area of skin, stroke, epilepsy, seizures, other _____

_____ Joint problems, pain, or stiffness – osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other _____

_____Bone conditions - osteoporosis, previous fracture, cancer, other_____

_____Herniated Disc or Bulging Disc, if so where _____

_____Headaches – (migraines, PMS, tension, cluster, other) _____

_____Diabetes (I or II)

_____Emotional difficulties (depression, anxiety, psychotic episodes) other_____

_____Stress _____Pregnant, or the possibility that you may be?

Asthma/Breathing difficulty	Multiple Sclerosis	Fibromyalgia
Dizzy/Vertigo	Hepatitis/Liver disease	Thyroid condition

Eating disorder Anemia Chronic infections

Lupus Kidney/Renal disease

HIV/AIDS Status _____

Cancer: Type _____ Location(s) _____
Year _____

_____

Do you have a pacemaker, internal defibrillator, insulin pump, metal fixator, or any other implanted medical device? _____

Is there anything else that you feel I should know that may not be on this intake form?

_____

Medications:

Please list all prescription medications you are **presently taking & reason for** medication (i.e., Zoloft for Depression, Percocet for pain, Accupril for High Blood Pressure):

_____

_____

_____

What type of exercise and/or sports, if any, do you perform or participate in?

_____

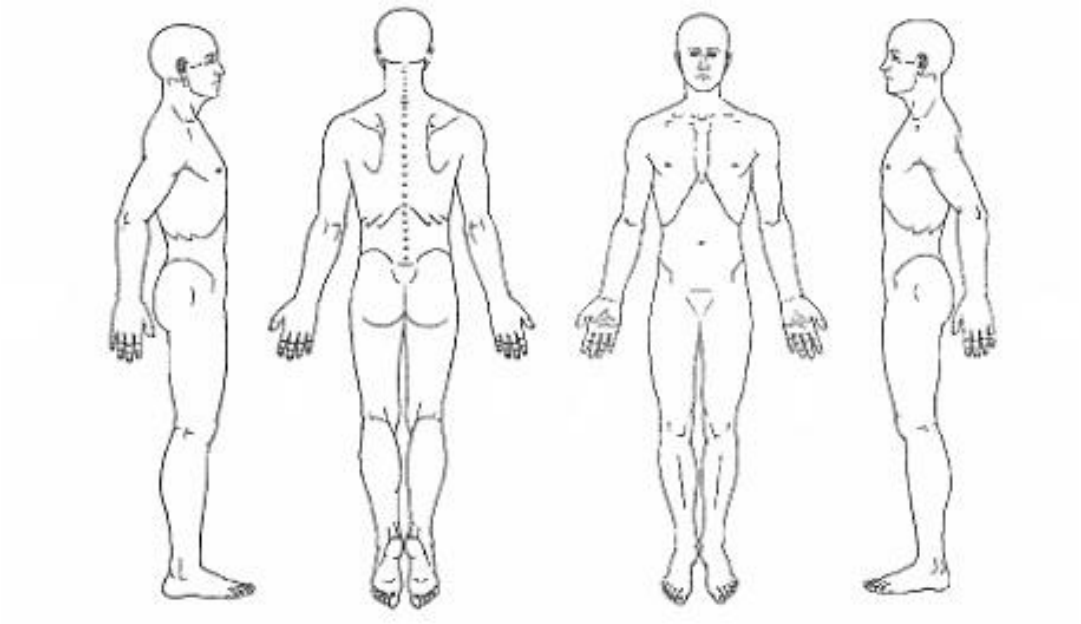
_____

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE & TRUE. IF MY MEDICAL/HEALTH STATUS CHANGES I WILL INFORM YOU IMMEDIATELY.

Signature: _____ Date: _____

(Please complete Body Diagrams on next page)

Please mark the body diagrams with the following letters to indicate what you have been recently experiencing: P = Pain; T = Tightness; N = Numbness/Tingling; W = Weakness.



Next to each letter, please write a corresponding number (0 through 10) that conveys the intensity of your experience.

0=No pain, 10=Emergency Room pain