

Name: \_\_\_\_\_

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

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

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

Occupation: \_\_\_\_\_

Referred by \_\_\_\_\_

### MEDICAL HISTORY

PRIMARY FAMILY PHYSICIAN: \_\_\_\_\_

Current medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Surgeries: \_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Claustrophobia      | <input type="checkbox"/> Tendinitis                  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Thyroid                     |
| <input type="checkbox"/> Blood clots            | <input type="checkbox"/> Hepatitis (type __) | <input type="checkbox"/> Ulcers                      |
| <input type="checkbox"/> Bursitis               | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Pace maker                  |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Hypertension        |  |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Glaucoma            | Do you take/use?                                     |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Lymph edema         | <input type="checkbox"/> Retin A                     |
| <input type="checkbox"/> Contact lenses         | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Renova                      |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Oral antibiotics            |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Sciatica            | <input type="checkbox"/> Hormone replacement therapy |
| <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Shingles            |  |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Stroke              |  |
| <input type="checkbox"/> Epilepsy               |  |  |

Do you have any difficulties with your hands or feet? \_\_\_\_\_

How much water do you drink a day? \_\_\_\_\_ Caffeine? \_\_\_\_\_ Alcohol? \_\_\_\_\_

How would you describe your daily level of stress?  low  moderate  high

I agree to communicate with my practitioner any time I feel that my well being is being compromised. I understand that licensed facial specialists, pedicurists and massage therapists DO NOT diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment , pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massages, facial, pedicures and reflexology ARE NOT substitutes for medical examinations or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the technician of any changes in my health status.

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