



Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

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

Emergency contact name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary care physician name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

How were referred to us: \_\_\_\_\_ Today's date: \_\_\_\_\_

What is your primary reason for booking an appointment? Select all that apply.

Relieve tension

Relieve stress

Relieve anxiety

Relieve pain

Improve mobility

Improve quality of life (sleep, mood, etc)

Relaxation

Other \_\_\_\_\_

Allergies & Sensitivities: \_\_\_\_\_

Are you pregnant?  Yes  No If yes, how many weeks: \_\_\_\_\_ Due date: \_\_\_\_\_

List current medications & conditions they are treating:

---

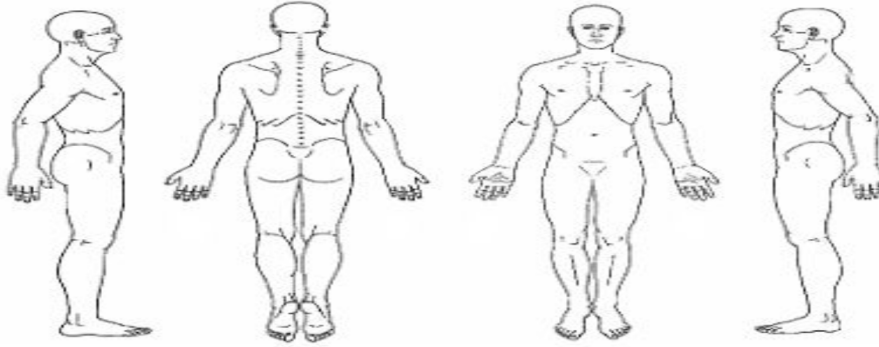
---

---

---

---

Please mark off areas for the primary area of pain / tension:



Please circle any of the following symptoms or conditions you are currently experiencing or have experienced in the past.

- |                     |                    |                          |
|---------------------|--------------------|--------------------------|
| Bleeding disorder   | Blood clot         | Bruise easily            |
| Bursitis            | Cancer / tumor     | Fibromyalgia             |
| Anxiety / stress    | Depression         | Mental disorder          |
| Diabetes            | Neuropathy         | Kidney disease           |
| Vertigo / dizziness | Hearing loss       | Vision loss              |
| Tendinitis          | TMJ disorder       | Phlebitis/varicose veins |
| Muscle weakness     | Numbness/tingling  | Sciatica                 |
| Osteoarthritis      | Osteoporosis       | Arthritis                |
| Seizures            | Stroke / CVA       | Tuberculosis             |
| High blood pressure | Low blood pressure | Multiple sclerosis       |

Any skin conditions? \_\_\_\_\_

Neurological conditions? \_\_\_\_\_

Heart condition? \_\_\_\_\_

Autoimmune disorder? \_\_\_\_\_

Digestive problem? \_\_\_\_\_

Endocrine disorder? \_\_\_\_\_

Respiratory disorder? \_\_\_\_\_

Areas of swelling? \_\_\_\_\_

Frequent headaches? If yes, how often? \_\_\_\_\_

Areas of numbness or decreased sensation? \_\_\_\_\_

History of joint replacement surgery? If yes, which joint(s)? \_\_\_\_\_

Any implants (pacemaker, insulin pump, metal, etc)? If yes, what/where? \_\_\_\_\_

Are you currently under medical supervision or receiving other medical interventions?

If yes, please describe: \_\_\_\_\_

Please describe any other injuries or health conditions:

\_\_\_\_\_  
\_\_\_\_\_

Notes/additional information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_