Medical History Form

Name _____ Date _____/_____/_____

Address _____City_____State_____ Zip_____

Email _____ Date of Birth_____/_____/_____

Emergency Contact (Name, Phone) _____

Home Phone (_____)_____ Cell Phone (_____)_____

Ok to contact you by Phone? email ? text ?

How did you hear about Achieve? Web search (search words)_____

Friend? (Who?_____) Ad/flyer? Event? Gift Cert? Other?_____

What is your primary purpose in seeking treatment today? _____

_____

Describe your physical activities at your job, at home, for fun. _____

Are you currently being treated by another health care professional (MD, PT, Chiroptactor, etc)? Yes No

For what purpose? _____

_____

List medications currently taking _____

_____

Please circle the following conditions you have or have had:

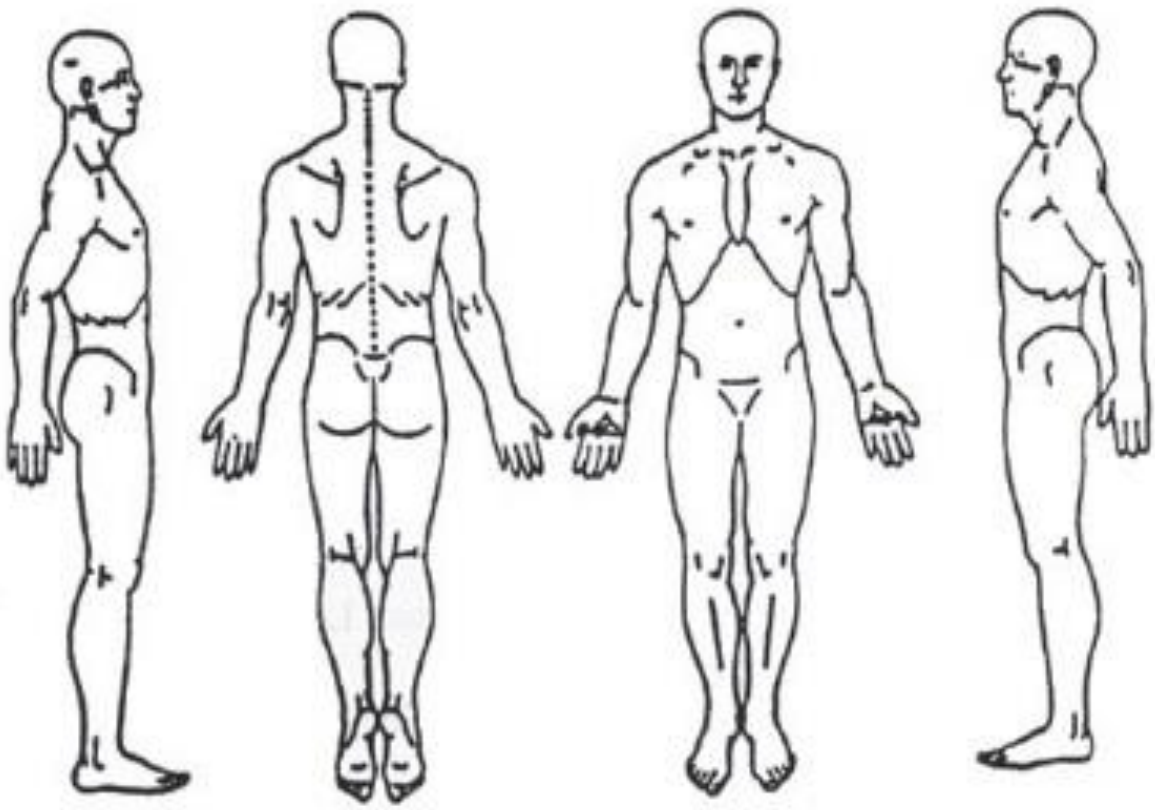
cancer	circulation problems	epilepsy
diabetes	blood clots	headaches
high/low blood pressure	phlebitis	skin disorders
heart condition	kidney condition	bruise easily

Have you ever had a Concussion? YES NO

Have you had any neurological issues/conditions? YES NO

OVER

Please use the diagram to indicate areas of pain and/or discomfort you are **experiencing now** or have experienced in the past 2 weeks.



Is there anything else you think I should know that might aid in your treatment?

INIT: _____ I have been given a copy of Achieve Therapeutics Policies and Procedures and I understand the policies around cancellation, payment, sharing of information and privacy.

I understand that the information I have supplied is strictly confidential and is used to help the massage therapist determine any indications or contraindications for massage. This information will only be shared with my express written consent.

Signature_____ Date _____/_____/_____