Health History Form

Name_____Date_____

Address_____City/State/Zip_____

Phone (mobile)_____Email_____

Date of birth_____Occupation_____

Physician (optional)_____

Why do you want therapy?_____

How did you hear about us?_____

Please mark all conditions that apply now or in the past:

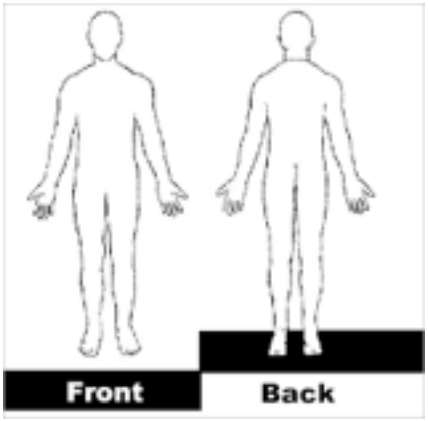
___Headaches/migraine	___Sinus problems	___Numbness/tingling
___Chronic pain	___TMJ or jaw pain	___Diabetes
___Fatigue	___High/low blood pressure	___Depression/anxiety
___Muscle/joint pain/injury	___Incontinence/leaking urine	___Tailbone injury
___Tension, stress	___Cancer or tumors	___Varicose veins
___Allergies	___Blood clots	___Endometriosis

Please list additional comments or any other medical conditions not listed above:

Surgeries:

Accidents:

Pregnancies/deliveries:



Shade/mark areas of pain/discomfort above.

Do you exercise regularly? Y/N If so, describe:

I attest the above information I have completed is true to the best of my knowledge, and I release Cindy Hodgson, Essential Therapies and any associates of any liability for any injury or complications as a result of falsified or incomplete information. I understand that the information given above is confidential under state law. Certain health conditions may require clearance by a physician, in this occurrence I give Cindy Hodgson and associates permission to contact my physician and/or refuse treatment until clearance is given from a physician. I understand that I or Cindy Hodgson and associates have the right to stop a treatment at any time. By signing below I give permission to have professional physical therapy and/or massage therapy administered to me. The policies and procedures of Essential Therapies are in compliance with the HIPAA Privacy Rules. A copy of the HIPPA procedures are available upon request.

Signed:_____ Date:_____