

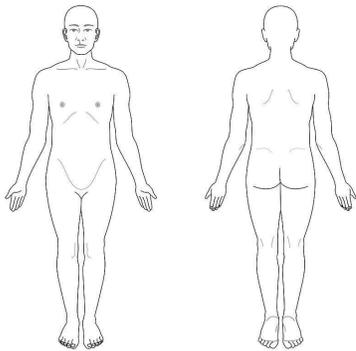
Personal Information

Name: _____ Birthday: _____ Occupation: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Primary reason for appointment/areas of pain or tension: _____



MARK (X) all current conditions. (P) For past conditions:

Headaches/migraines _____ Chronic pain _____ Fatigue _____

Muscle/ Joint pain _____ Major physical issues _____ Numbness/tingling _____

Difficulty sleeping _____ Sinus problems _____ Allergies/sensitivities _____

Arthritis/ Tendonitis _____ Rashes/ hives _____ Athlete's foot/ warts _____

Jaw pain/TMJ _____ Cancer/ Tumors _____ Infectious disease _____

Respiratory issues _____ Blood clots _____ Varicose veins _____

Hernia _____ Pregnancy _____ High/Low blood pressure _____

Birth control _____ Heart/Circulatory _____ Abdominal problems _____

Digestive problems _____

Explain areas noted above: _____

Other medical conditions not listed _____

Current medications,(Aspirin, Ibuprofen, Herbs, Supplements, etc.): _____

Surgeries & Date (if applicable): _____

Accidents & Date: _____

Primary Sleeping position: _____ Dominate hand: _____

Forms of regular stress reduction (Activities, Hobbies, Exercise, or Sport participation)

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