Orthopedic Treatments

Transformations for Body and Spirit
Confidential Information

Name:_____Date of Birth:_____

Address:_____

Mobile Phone Number:_____Email:_____

Whom may we thank for referring you?_____

Primary Physician: _____PrimaryDentist:_____

Social Status: Single/Married/Widowed/Separated/Divorced/Domestic Partnership

How many children do you have?_____ How many people live in your home?_____

Occupation_____ Do you enjoy your occupation?_____

When are you the happiest?_____

Please mark if you have you ever been diagnosed with or treated for: ___Stroke ___Heart Attack ___Cancer ___HIV/AIDS ___Blood Clots ___High/Low Blood Pressure ___Glaucoma ___Steven/Johnson Syndrome ___Osteoporosis/Osteopenia Are you pregnant?____ If so, what is your due date?_____

Please list any allergies :_____

Current Medications (or attach list):_____

Current supplements and vitamins:_____

Please list all medical conditions:_____

Please list all surgeries:_____

What is your primary complaint today?_____

What other concerns do you have?_____

What would you like to accomplish during your sessions?_____

What else do you think we should know?_____

I understand that the treatments provided at Transitions for Body and Spirit including Orthopedic Massage Therapy are not a substitution for medical care. I agree that my participation is by choice and agree to hold all therapists, and Amy Weigold, specifically, free from all fault. I understand that sexual solicitation is never appropriate at Transformations for Body and Spirit.

_____

signature date