

Name: _____ Date of Birth: _____

Address: _____

Mobile Phone Number: _____ Email: _____

Whom may we thank for referring you? _____

Primary Physician: _____ Primary Dentist: _____

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

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

What is your occupation _____ Do you enjoy it? _____

When are you the happiest? _____

When are you the least happy? _____

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 ___ Cold sores/HSV ___ Skin Sensitivity or Rashes ___ 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 would you like to accomplish during your session today? _____

_____ During the next three months? _____

_____ By the end of a year? _____

What else do you think we should know? _____

I understand that the treatments provided at Transitions for Body and Spirit including Orthopedic Massage Therapy, Rejuvenation and Sculpting, and Ionic Detoxification 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