Touch Based Therapies Health History

NAME: ____

Address:	Home Phone:
	Work Phone:
City:	Cell Phone:
Postal Code:	E-Mail:
Birth Date: (mm/dd/yy)	OK to contact via E-Mail: yes/no
Occupation:	Employer:
Family Doctor:	Doctor's Phone #:

Are you here as a result of a Motor Vehicle Accident? YES NO

(If yes) Name of Insurance Company:
Name of Insurance Contact Person (adjustor) :
Date of Accident:
Claim Number:

All clients to self-pay for services received even when such has been prescribed by their healthcare provider. We will provide an invoice on company letter head which lists the service codes that were on request. You can submit this invoice directly to your insurance company, Flexible Spending Account (FSA) provider, or Health Spending Account (HSA) provider, or Health Reimbursement Accounts (HRA) for reimbursement.

How did you hear about us?____

Medications:____

Past Surgeries or Injuries:	Date:	Treatment Received:
___________________________	__________	__________________
___________________________	__________	__________________
___________________________	__________	__________________

Current or Past Therapy received (please circle): Chiropractic, Physiotherapy, Massage Therapy, Acupuncture, Homeopathic, Cranio-Sacral Therapy, Podiatry
Other:____________________

Water Intake: ____ cups/day **Caffeine Intake:**_____ cups/day

Employment hours weekly _____ Outdoor hours monthly _____

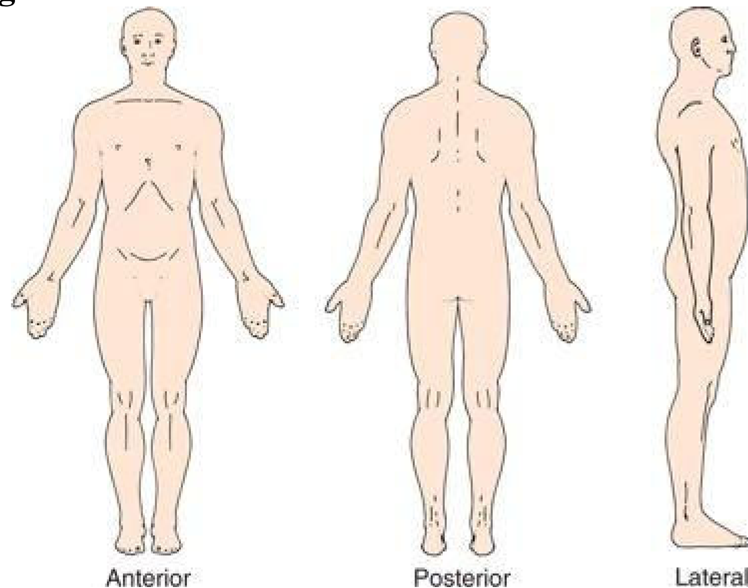
I authorize the release any necessary health information to the therapist, and treatment by massage therapy or energy therapy.

Signature:__________________________________ Date______________________

Please indicate any of the following conditions that you have:

__Arthritis
__Diabetes
__Thyroid Condition
__Dizziness/Fainting
__Low/High Blood Pressure
__Heart Condition
__Chest Pain
__Pace Maker
__History of Cancer
__Allergies
__Epilepsy/Seizures
__Shortness of Breath
__Asthma
__Bronchitis
__Hearing Impairment
__Pregnancy
__Metal Implants (Incl IUD)
__Loss of Sensation
__HIV/AIDS
__Headaches/Migraines
__Hernia
__Depression
__Osteoporosis
__Smoking History
__Raynauds
__Sleeping Problems
__Cough
__Vision Difficulties
__Swallowing Difficulties
__Slurred Speech
__Memory Problems
__Balance Problems
__Recent Falls/Blackouts
__Unexplained Weight Loss/Gain
__Bowel and Bladder Difficulties
__Varicose Veins
__Parkinson's
__Multiple Sclerosis
__Blood Diseases
__Hepatitis

Please indicate any areas which you presently suffer pain or discomfort by shading in that area on the diagram:



I hereby authorize the release of my health information to ILI for the purposes of planning and implementing my treatment plan. I further **consent to treatment.**

Signature:____________________________________ Date:_____________________