Essential Kneads Inc.

Confidential Case History

Name _____ Phone (h) _____ (c) _____

Address _____ City _____ State _____ Zip _____ DOB _____ Age _____

Who is responsible for this account? _____ M/F _____ Marital Status _____ # of children _____

Occupation _____ Email address: _____

Height _____ Weight _____ How did you hear about us? _____ Have you ever had a professional massage? Y N

If so, how long ago? _____ What is your goal for today's session? _____

Please check all that apply:

___ Headaches
___ Heart issues
___ Numbness/Stabbing/Nerve Pain
___ Abdominal Pain
___ AIDS
___ Arthritis
___ Cancer
___ Colitis/ IBS
___ Diabetes: Type I /Type II
___ Epilepsy/Seizures/ Dizziness
___ Pregnant _____ Wks. (Please Reschedule if under 12 Wks.)
___ Thyroid
___ Skin Irritations
___ Fibromyalgia
___ Inflammation in Throat
___ Tuberculosis
___ Perfume/Chemical Sensitivity
___ Allergies
___ Joint Swelling
___ Pleurisy/ Chest Pain
___ Shortness of Breath
___ Scoliosis
___ High/Low Blood Pressure
___ Contagious Diseases
___ Osteoporosis
___ Gall Bladder Trouble
___ Kidney Trouble
___ TMJ Dysfunction
___ Bruise easily

Are you currently undergoing any treatment for any health condition? Y N If yes, please explain: _____

_____

Current medications: _____

Please check if you are taking any of the following:

___ Laxatives ___ Sedatives ___ Aspirins ___Insulin ___ Herbs ___Vitamins ___ Minerals ___Sleep Aids

Please list the following – please include approximate dates:

Past surgeries: _____

Major car accidents: _____

Broken bones: _____

(Please list any other health information you would like us to know on the back of this form.)

How much do you exercise? _____ **(1 = heavy 2 = moderate 3 = light 4 = none)**

How much do you consume? Alcohol ___/wk Coffee ___/day Tea ___/day Tobacco ___/day Water ___/day

How can we contact you?
Mail? Y / N Email? Y / N Voicemail? Y / N Text Message? Y / N

Mobile Provider _____ (For Auto. Text Reminders)

*There is a $25 fee for returned checks.
**A 24 hour notice is required for cancellation, or you will be charged for the missed appointment.

Signature _____ Date _____

Please circle areas of pain or tightness

Draw lightning to indicate nerve pain

-S. O. A. P. Notes