*KRISTIN SLOTH ~ LICENSED MASSAGE THERAPIST, CERTIFIED ROLFER® *

PERSONAL HEALTH INFORMATION

Name: _____ Date: _____ Referred by: _____

Address: _____ Phone – Cell: _____ Home: _____

City_____ State_____ Zip: _____ Primary Health Care Provider:_____ Phone:_____

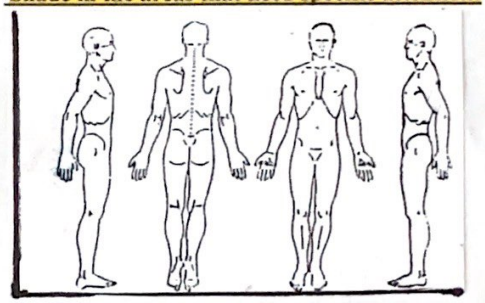
Date of Birth: _____ Occupation: _____ Emergency Contact: _____ Phone: _____

EMAIL: _____

REASON for MASSAGE THERAPY or ROLFING Injury - Pain - Tension - Movement Dysfunction - Stress - Relaxation - Other_____

HISTORY OF SPECIFIC PAIN/TENSION

Shade in the areas that need specific attention:



Location: _____

When did it start? _____ What was the activity? _____

Have you seen a physician for this? __No __Yes - Date_____ Diagnosis: _____

Are you currently seeing a medical practitioner? __No __Yes - For: _____

HEALTH HISTORY - (check with P for past and/or C for current condition)

MUSCULO-SKELETAL
__ lower back, hip, leg pain
__ neck, shoulder, arm pain
__ headaches/head injuries
__ spasms/cramps
__ jaw pain/TMJ
__ tendonitis ___ bursitis
__ arthritis ___ sprains/strains
__ bone or joint disease
__ broken/fractured bones
__ lupus ___fibromyalgia
__ other_____

CIRCULATORY
__ high ___ low blood pressure
__ blood clots/hematoma
__ breathing difficulties
__ lymphedema
__ varicose veins/phlebitis
__ heart condition
__ allergies
__ sinus problems
__ other_____

NERVOUS SYSTEM
__ numbness/tingling
__ chronic pain
__ fatigue
__ sleep disorders
__ other_____

SKIN
__ allergies
__ rashes
__ athletes foot
__ warts
__ other_____

DIGESTIVE
__ diverticulitis
__ irritable bowel syndrome
__ constipation
__ gas/bloating
__ Other_____

REPRODUCTIVE
__ pregnant? Stage_____
__ PMS
__ other_____

INFECTIOUS DISEASE
__ Disease name(s)_____
_____
_____

OTHER __ cancers/tumors __ diabetes __ eating disorders __ depression __ drug/alcohol addiction __ nicotine/caffeine addiction

__ operations _____

***Massage Therapy** is not involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed. The **Massage Therapist** does not treat, prescribe or diagnose an illness, disease, or any other physical or mental disorder of the person. Nothing said or done by the **Massage Therapist** should be misconstrued to be such.*

Cancellation Policy: By signing below I understand that if, for any reason, I am unable to keep an appointment I will give at least *24 hours notice or full payment* for that session. (hazardous weather, family & medical emergencies excluded.)

_____ _____ _____

Print Name *Signature* *Date*