2200 Harvard Rd. Suite 101
Lawrence, KS 66049
Phone: (785) 842-0656
Fax: (785) 842-0071

Massage Therapy

Health History Form

Lawrence Therapy Services, LLC
Baldwin Therapy Services

814 High Ste A•PO Box 368
Baldwin City, KS 66006
Phone: (785) 594-3162
Fax: (785) 594-3257

First Name:__________________________________ Last Name:____

Address:_________________________________ City:__________________________ State:________ Zip:__________

Phone (H):____________________________ (C):___________________________ (W):__________________________

Birth Date:________/________/_________ Occupation: ____

Emergency Contact: ___________________________ Phone: _____________________ Relationship: _______________

Would you like to be on our e-mail list to receive coupons and special offers? Y N

E-mail Address:____

How did you hear about us? ____

Please check if you wear any of the following: Contacts? _________ Dentures? _________ Hearing Aid? __________

Is stress contributing to your visit today? Y N Stress level: Low 1 2 3 4 5 High

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: ____

More than 5 years ago: ____

Do you have any chronic, ongoing pain that you deal with on a regular basis? Y N

Please explain: ____

Describe what activities cause this pain and/or make it worse: ____

Have you been evaluated by a MD, PT, OT, or DC for this condition? Y N

Please list all current medications: ____

Check any or all that apply to your present health:

_____ Headaches	_____ Numbness/tingling	_____Varicose veins
_____ Vision problems	_____ Blood clots	_____ High/low blood pressure
_____ Sinus problems	_____ Scoliosis	_____ Muscle or joint pain
_____ Jaw pain/teeth grinding	_____ Arthritis	_____ Diabetes
_____ Fatigue	_____ Tendonitis	_____ Cancer/tumors
_____ Depression	_____ Edema	_____ Infectious disease
_____ Sleep difficulties	_____ Osteoporosis	_____ HIV/AIDS

Women: Pregnant? N Y Due Date: ____

Please provide any additional information on the back of this form, thank you!

To ensure that we can continue to meet your massage therapy needs, please keep us informed of any changes in your health.

____ ______________________________

Signature **Date**

____ ______________________________

Parent/Guardian **Date**

12/10/09