THERAPEUTIC MASSAGE AND NUTRITION CENTER
2456 N. WOODLAWN, SUITE 1A, WICHITA, KS 67220
(316) 425-8003

PERSONAL INFORMATION

NAME: _____DATE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____
EMAIL: _____ DATE OF BIRTH: _____ AGE: _____ SEX: _____
EMERGENCY CONTACT: _____ EMERGENCY CONTACT PHONE: _____
MARITAL STATUS: _____ NAME OF SPOUSE (if married): _____ PHONE: _____
OCCUPATION: _____ REFERRED BY: _____
ARE YOU CURRENTLY UNDER DOCTOR CARE OR HAVE YOU SEEN A DOCTOR IN THE LAST 12 MONTHS? _____
IF YES, FOR WHAT REASON(S)? _____ PHYSICIAN(S): _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT: _____
HOW DID IT HAPPEN? _____
WHEN DID YOUR CONDITION START? _____ IS THE CONDITION GETTING PROGRESSIVELY WORSE? _____
IS YOUR CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____
WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____
WHAT ACTIVITIES LESSEN YOUR CONDITION? _____
IS YOUR CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____ OTHER? _____
OTHER DOCTOR(S) SEEN FOR THIS CONDITION: _____
TYPE OF TREATMENT(S) TRIED: _____
RESULTS: _____

HABITS

- ☐ Alcohol: Type _____ Amount _____
- ☐ Caffeine: Coffee, cups daily _____ Other _____
- ☐ Diet: Salt intake _____ Fat intake _____
  Other _____
- ☐ Exercise: Routine _____
  _____
- ☐ Sleep: Difficulty falling asleep _____
  Continuity disturbances _____
  Early morning awakenings _____
  Daytime drowsiness _____ Other _____
- ☐ Smoking: Packs daily _____How long? _____
  Interested in stopping? _____

CURRENT MEDICATIONS: _____
SUPPLEMENTS: _____
(DRUG) ALLERGIES: _____
HOSPITALIZATION(S) (include date, reason): _____

MEDICAL HISTORY – please mark the conditions that apply to your personal health history.

- ☐ Ringing in ears _____
- ☐ Ear infections – frequent _____
- ☐ Dizziness/fainting _____
- ☐ Failing vision _____
- ☐ Eye infections _____
- ☐ Nose bleeds _____
- ☐ Sinus trouble _____
- ☐ Sore throat – frequent _____
- ☐ Hayfever/Allergies _____
- ☐ Pneumonia _____
- ☐ Bronchitis/Chronic cough ____
- ☐ Asthma/Wheezing _____
- ☐ Chest pain _____
- ☐ High/low blood pressure _____
- ☐ Heart Disease_ _____
- ☐ Swollen ankles _____
- ☐ Leg pain – walking _____
- ☐ Varicose veins/phlebitis _____
- ☐ Loss of appetite _____
- ☐ Difficulty swallowing _____
- ☐ Indigestion or heartburn _____
- ☐ Persistent nausea/vomiting __
- ☐ Peptic ulcers _____
- ☐ Abdominal pain – chronic ____
- ☐ Gall bladder trouble _____
- ☐ Jaundice/Hepatitis _____
- ☐ Change in bowel habits _____
- ☐ Diarrhea _____
- ☐ Constipation _____
- ☐ Diverticulitis _____
- ☐ Crohn's/IBS/UlcerativeCholitis__
- ☐ Bloody or tarry stools _____
- ☐ Hemorrhoids _____
- ☐ Hernia _____

Urination:

- ☐ Overnight > twice _____
- ☐ Painful _____
- ☐ Loss of control _____
- ☐ Decrease in force/flow _____

- ☐ Urine infections – frequent ___
- ☐ Blood in urine _____
- ☐ Kidney stones _____
- ☐ Venereal disease _____
- ☐ CarpelTunnelSyndrome _____
- ☐ ThorasicOutletSyndrome_____
- ☐ Weight loss – recent _____
- ☐ Anemia _____
- ☐ Bruise easily _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Thyroid disease _____
- ☐ Convulsions/seizures _____
- ☐ Stroke _____
- ☐ Tremor/hands shaking _____
- ☐ Muscle weakness _____
- ☐ Numbness/tingling sensations
- ☐ Headaches – frequent _____
- ☐ Arthritis/rheumatism _____
- ☐ Osteoporosis _____
- ☐ Back pain – recurring _____
- ☐ Bone fractures/Joint injury ___
- ☐ Gout _____
- ☐ Foot pain _____
- ☐ Cold numb feet _____
- ☐ Rashes _____
- ☐ Hives _____
- ☐ Psoriasis _____
- ☐ Eczema _____
- ☐ Nervousness _____
- ☐ Depression _____
- ☐ Memory loss _____
- ☐ Moodiness – excessive _____
- ☐ Phobias _____
- ☐ Mental illness _____
- ☐ Lactose intolerant _____
- ☐ Prostate disease _____
- ☐ Sexual/menstrual dysfunction
- ☐ Frequent infections _____
- ☐ Diphtheria _____
- ☐ Tetanus _____
- ☐ Chicken pox _____
- ☐ Polio _____
- ☐ Mumps _____
- ☐ Measles _____
- ☐ Rubella _____
- ☐ Rheumatic fever _____
- ☐ Scarlet fever _____
- ☐ Tuberculosis _____
- ☐ Herpes _____
- ☐ Other _____

FEMALES (please complete):

- ☐ Pregnant _____
- ☐ Planning pregnancy _____

Menstrual flow:

- ☐ Regular _____
- ☐ Irregular _____

- ☐ Pain/cramps _____

Days of flow _____
Length of cycle _____
1st day of last period _____

- ☐ Pain/bleeding during/after sex

Number of Pregnancies _____
Abortions _____
Miscarriages _____
Live births _____
Birth control method _____
B.C. pill (name) _____

- ☐ Flushing/menopause _____

Date of last pap test _____

- ☐ Normal _____
- ☐ Abnormal _____

Date of last mammogram _____

- ☐ Normal _____
- ☐ Abnormal _____

FAMILY HISTORY - please provide the following information about your family health history.

Relationship	Age, if living	Age at death	State of health or cause of death
Father			
Mother			
Brothers and Sisters			
Spouse			
Children			

Indicate any blood relatives who have had the following:

Cancer _____
Diabetes _____
Gout _____ Blood disease _____
Glaucoma _____ Epilepsy _____
Tuberculosis _____ Heart disease _____
High blood pressure _____
Back problems _____ Rheum. Arthritis _____
Other _____

AGREEMENTS

_____ (initial) I understand that all services are rendered on a cash, check or credit card basis. Unless other arrangements have been made, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.

_____ (initial) Cancellation policy – I understand that any appointment not cancelled more than 12 hours prior to the scheduled time will be billed in full. There will be one "grace" given for one missed/late cancelled appointment.

_____ (initial) The information I have provided is truthful and complete to the best of my knowledge. I assume responsibility for advising the therapist of any changes in my condition. Should I experience pain or discomfort during a massage, I will immediately inform the therapist.

_____ (initial) I understand that the Therapeutic Massage Center does not diagnose or prescribe and is not a substitute for physician diagnosis and treatment.

_____ (initial) I understand that the HIPPA policy of this office will not allow for any transfer of personal information without written/signed consent of the client.

Client Signature: _____ Date: _____

(For Minor) Parent/Guardian Signature: _____ Date: _____