THE COMFORT ZONE

Wholistic Healing Inside & Out

Confidential Case History

Please fill out the following information as completely as possible in order to assist your therapist in providing the best possible care.

Personal History

First Name:	**Date of Birth:**
Last Name:	

Address:	
City:	**Postal Code:**

Home Phone: ( )	**Work Phone: ( )**
Cell Phone: ( )	**Other: ( )**
E- Mail:	

Occupation:	**Employer:**

Doctor's Name: _____ Chiropractor: _____

Were you referred? Yes _____ No _____ by Whom: _____

Health History

Are you currently being treated by a Doctor, Chiropractor or other Practitioner? Yes _____ No _____ if so, by whom? _____

Present Injury or complaints: _____

Is your condition Job Related: _____ Auto Related: _____ other: _____

What aggravates the condition? _____

What relieves the condition? _____

What is your general condition of Health? Excellent ____ Good ____ Fair ____ Poor ____

Have you ever had a serious illness? Yes ____ No ____ if so, please describe it: _____

_____

Have you had any operations? Yes ____ No ____ Is so, what and when: _____

_____

Have you had any traumatic accidents or broken bones? Yes ____ No ____ if so please explain: _____

_____

Do you wear prostheses? (Glasses, contacts, metal plates, pins/wires, dentures, hearing aids) _____

_____

Are you on any medication? Yes ____ No ____ if so, please list: _____

_____

Have you taken a pain killer today? (Aspirin, Tylenol…) _____

THE COMFORT ZONE

Wholistic Healing Inside & Out

CHECK ALL THAT APPLY

	Circulatory		Spasms, cramps		**Skin**
	High Blood Pressure		Sprains/Strains		Sensitive skin
	Low blood pressure		Tendonitis/Bursitis		Rashes
	Poor circulation		Weak or sore muscles		Herpes/Shingles
	Heart disease		Arthritis		Athlete's foot/warts
	Blood clots		Disk problems		Eczema/Dermatitis
	Varicose veins		Other		Scabies/Impetigo
	Chest pain		**Nervous System**		Allergies: Scents
	Swelling/edema		Migraine headache		Allergies: Oils
	Hemophilia		Anxiety		Allergies: Lotions
	Other		Depression		Allergies: Detergents
	Gastrointestinal System		Numbness, tingling		Other
	Hepatitis		Dizziness, ear ringing		**Other**
	Bowel dysfunction		Loss of memory		Cancer/ tumors
	Gas		Fatigue		Lupus
	Bloating		Concussion		HIV/Aids
	Diarrhea		Nervousness		Bladder
	IBS		Sciatica, shooting pain		Chronic pain
	Abdominal pain		Epilepsy		Kidney dysfunction
	Other		MS		Thyroid dysfunction
	Musculoskeletal		Stroke		Pregnant # _____ weeks
	Headaches		Other		Painful/emotional menses
	Lower back		**Respiratory**		Diabetes
	Neck, shoulder / arm pain		Asthma		Other
	Stiff or painful joints		Breathing difficulties		**Habits**
	Scoliosis		Bronchitis		Tobacco
	Broken bones		Allergies		Alcohol
	Spinal Problems		Emphysema		Drugs
	TMJ, Jaw pain		TB		Coffee
	Hip		Other		Tea
	Leg pain				Soda
					Other

THE COMFORT ZONE

Wholistic Healing Inside & Out

If desired, CUPPING THERAPY will be provided during this treatment and it has been explained to me that there is the possibility of local discoloration following this therapy. I understand that these marks last from a few hours to a week following the treatment. I understand that the aggressive exfoliation and extreme exercise or temperature changes can produce undesirable aftereffects following cupping.

I_____(please print name) agree to allow the Cupping Practitioner to perform cupping on me and I have read and understood all of the information stated above.

___ Please initial here if you are OK with us sending you email updates on our business. We will not share your email address with anyone.

I _____ (please print name) declare that the previous information has been answered to the best of my knowledge and that any information that I may have omitted releases the massage therapist and The Comfort Zone from any responsibility for problems that may arise from these omissions.

By signing below I certify that I have been informed about the treatment being offered and fully understand and hereby consent to the treatment of my own free will.

It is not the intention of The Comfort Zone to provide specific medical advice but rather to provide clients with information to better understand their health and their specific conditions. Specific medical advice will not be provided. By using the products and services provided by The Comfort Zone, the client willingly assumes all risks in connection with such use.

_____ _____

Signature Date