United Wellness Spa Client Information

(Please Print Clearly)

Today's Date: ________/______/______ For office use only - Acct No:_______________

PERSONAL INFORMATION

Patient's Last Name First Name Middle	Gender: ❑ M ❑ F	Date of Birth / /	Marital Status ❑Single ❑ Mar. ❑Div ❑Sep ❑Wid.
Street Address City State Zip Code	Email Address:		
Cell Phone No. ( )	Home Phone No. ( )	Work Phone No. ( )	

IN CASE OF EMERGENCY NOTIFY

Last Name	First Name	Relationship
Street Address City State Zip Code		Email Address:
Cell Phone No. ( )	Home Phone No. ( )	Work Phone No. ( )

HEALTH HISTORY

Condition / Body System	Self (Explain)	Condition / Body System	Self (Explain)
Allergies	❑	High Blood Pressure	❑
Arthritis	❑	Hepatitis	❑
Neurological (Brain, Nerves)	❑	Gastrointestinal	❑
Aids / HIV	❑	Immune	❑
Bleeding Disorders	❑	Muscle / Joint / Bone	❑
Cancer	❑	Psychological	❑
Circulatory Problems	❑	Respiratory (Lung, Breathing)	❑
Ear, Nose, Throat	❑	Skin	❑
Endocrine (Diabetes, Thyroid etc.)	❑	Stroke / TIA	❑
Heart Problems	❑	Heart Problems	❑

Past / Present Musculoskeletal injury (i.e. muscle pulls, sprains, fractures, surgery, back pain, arthritis or any other general discomfort.)

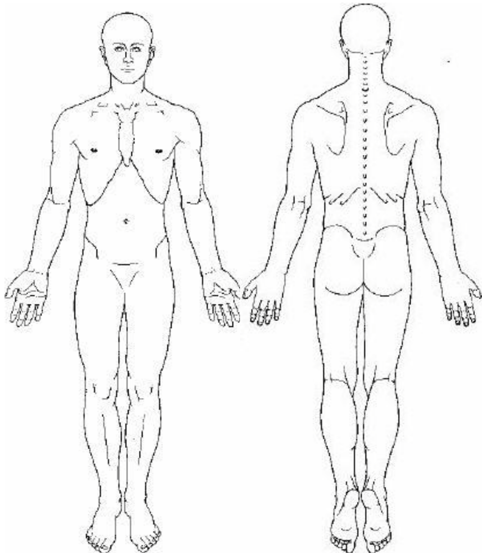
Region	Condition	Date	Outcome / Current Implication
Head / Neck			
Shoulder			
Arm /Elbow / Wrist/ Hand			
Back			
Hip / Pelvic			
Knees			
Leg / Ankle / Foot			

Please tell us about any hospitalizations, serious illnesses or surgeries:

Date	Reason	Hospital	Outcome

Currently Pregnant? ❑ No ❑Yes	**Due date:**	

PHYSICAL COMPLAINT *(circle the area of discomfort)*



What is the frequency of your discomfort?

- ❑ Rare
- ❑ Occasional
- ❑ Frequent
- ❑ Constant

Please rate your pain on a Scale of *0* to *10* (*0 = no pain, 10 = severe)*

Neck	1	2	3	4	5	6	7	8	9	10
Lowback	1	2	3	4	5	6	7	8	9	10
____________________	1	2	3	4	5	6	7	8	9	10
____________________	1	2	3	4	5	6	7	8	9	10

Other concerns:

HEALTH HABITS

List any vitamins, diet supplements or medications:

Name	Dosage	Frequency Used

Exercises Intensity	❑ **Sedentary** (no exercise)	❑ **Mild Exercise** (i.e., climb stairs, walk 3 blocks, golf)	❑ **Occasional Vigorous** (i.e., work or recreation, less than 4x/week for 30 min.)	❑ **Regular Vigorous** (i.e., work or recreation 4x/week for 30 min.)

Eating Habit	Rate the quality of your eating habit. *Terrible* 0 1 2 3 4 5 6 7 8 9 10 *Perfect*
Specific food / nutrition plan:	❑ No ❑ Yes — *Describe please:*
Caffeine Source:	❑ None ❑ Coffee ❑ Tea ❑ Cola — # of ______ Cups/Cans Per______Day
Alcohol Intake	❑ None ❑ Daily ❑ Weekly ❑ Monthly ❑ Socially ❑ _____________
Tobacco	Do you use tobacco? ❑ Yes ❑ No ❑ Not any more. # of Packs/day_________ # of Years ____________ # of Years Quit:________
Fluid Intake	**Daily Major Sources of Fluid/Water** ____________________ **Liquid Intake** _____________**cups/day**
Stress Level:	Rate your daily stress level. *No stress at all* 0 1 2 3 4 5 6 7 8 9 10 *Highly Stressed out* Rate your stress management ability. *Non-existent* 0 1 2 3 4 5 6 7 8 9 10 *Perfect*

What do you do to relax? How often do you do these activities?

Can you describe your perfect health?

Do you have any experience with holistic, natural or alternative healing methods? Have you had previous bodywork experience?

Please explain your reasons for your visit with United Wellness Spa? What are your expectations?

Is there anything else I need to know about you to best serve you needs?

PAYMENT POLICY

All appointment times will be reserved with a credit card. Cancellations must be made 24 hours in advance of the scheduled time to avoid any cancellation fees.

CONSENT FOR CARE

I understand that my treatment is provided by a holistic healthcare provider and it is not substitute for medical diagnosis or treatment. I have stated all of my known conditions and will inform my practitioner of any changes in my health status.

I have read the center policy and agree to abide by them. I also understand that it is my choice to receive bodywork and I give my consent.

X____ SIGNATURE

______________________ DATE