Mudwraps to Manicures

BEDFORD, NS SPA SERVICES

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential. Your written permission will be required to release any information.

Name _____ Email _____

How did you hear about Mudraps to Manicures? _____

Home Phone _____ Cell Phone_____ Work Phone_____

Date of Birth(MM-DD-YY)_____ Occupation_____

Do you have insurance coverage for massage? ☐Yes ☐No

If yes, were you referred by doctor? ☐Yes ☐No

Insurance Company _____ Policy# _____ ID# _____

Doctor's Name _____ Phone _____

Last Checkup Date _____

Have you had a professional massage before? ☐Yes ☐No

If yes, approximate date _____

Do you see other healthcare practitioners? ☐Chiro ☐Physio ☐Osteo ☐Other _____

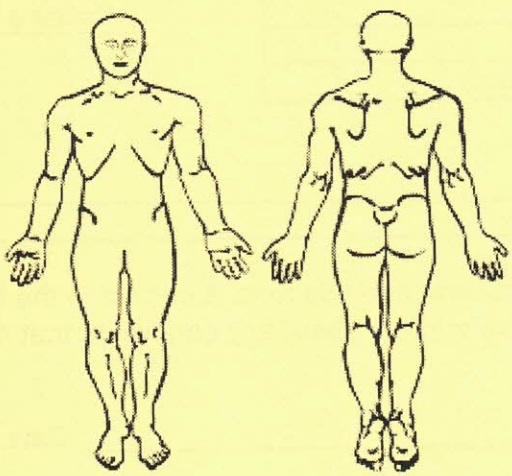
Current Medications _____

Previous Major Illnesses/Operations(include dates) _____

Family History of _____

Major Accidents (include dates) _____

Other serious Medical Conditions _____



Please indicate which areas you would like to focus on.

Headaches	
Joint stiffness/swelling	
Spasms/Cramps	
Strains/Sprains	
Tendonitis	
Bursitis	
Arthritis	
Osteoporosis	
Scoliosis	
Bone/Joint Disease	
Dizziness	
Fainting	
Shortness of Breath	
Cold Feet/Hands	
Varicose veins	
Blood Clots	
Stroke	
Heart Condition	
High Blood Pressure	
Allergies	
Asthma	
Emphysema	
Chronic Bronchitis	
Lymph Edema	
Rashes	
Athlete's Foot	
Warts	
Intestinal Gas/Bloating	
Diarrhea	
Indigestion	
Constipation	
Colitis	
Crohn's Disease	
Diverticulitis	
Irritable Bowel Syndrome	

Cancer	
Diabetes	
Numbness/Tingling	
Twitching	
Fatigue	
Chronic Pain	
Sleep Deprivation	
Ulcers	
Paralysis	
Herpes/Shingles	
Cerebral Palsy	
Epilepsy	
Chronic Fatigue Syndrome	
Multiple Dystrophy	
Fibromyalgia	
Parkinson's Disease	
Spinal Cord Injury	
Dysmenorrhea	
Pelvic Inflammatory Disease	
Endometriosis	
Prostate Problems	
Loss of Appetite	
Forgetfulness/Confusion	
Depression	
Hearing Impairment	
Visual Impairment	
Infectious/Contagious Conditions	
Chronic Kidney Disease	
Local Irritable Skin Condition	
Nicotine Use	
Alcohol Use	
Caffeine Use	

Other Health Problems:

_____

_____

By signing below, you confirm that this form is correct to the best of your knowledge, and you have told me about any conditions that may be relevant to your treatment.

Signature _____ Date _____