DIGESTIVE

- ☐ Poor Appetite
- ☐ Belching/Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Ulcer
- ☐ Vomiting

EYE/EAR/NOSE/THROAT

- ☐ Allergies
- ☐ Frequent Colds
- ☐ Glasses or Contacts
- ☐ Hearing Aid
- ☐ Hearing Loss
- ☐ Sinus Infection
- ☐ Swollen Glands

RESPIRATORY

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

WOMEN

- ☐ Pregnant
  Due Date_____
- ☐ Gynaecological conditions,
  what?_____
- ☐ Pre-menopausal
- ☐ Menopausal
- ☐ Post-menopausal
- ☐ Birth Control
  type_____

LIFESTYLE QUESTIONS

Regular Eating Habits Yes____ No____

Do you take vitamins? Yes____ No____

type_____

frequency_____

Regular Exercise Yes____ No____

type_____

frequency_____

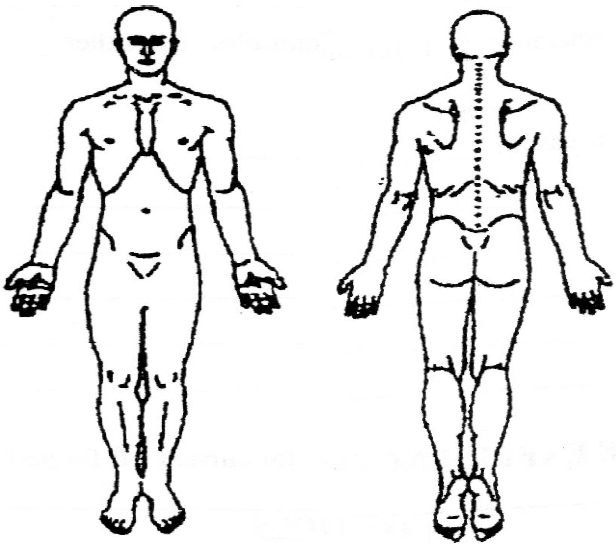
Energy Level High___ Average___ Low___

Do you suffer from stress? Yes____ No____

Do you use a computer Yes____ No____

how many hours per day _____

PLEASE INDICATE PAINFUL AREAS WITH AN X



WHICH BEST DESCRIBES YOUR PAIN

- ☐ sharp
- ☐ deep
- ☐ constant
- ☐ shooting
- ☐ superficial
- ☐ burning
- ☐ aching
- ☐ dull
- ☐ throbbing
- ☐ intermittent
- ☐ poorly localized
- ☐ well localized
- ☐ brief, transient

What increases your pain? _____

_____

What relieves your pain? _____

_____

PATIENT POLICY AGREEMENT

- I authorize Georgia Poulis, RMT to treat my condition as she feels necessary and appropriate, in order to achieve a positive goal. I have completely disclosed to the therapist my medical history.
- I agree that my health and/or accident insurance are in agreement between the carrier and myself and I am fully responsible for my appointment fees. I understand that all acounts are due and payable at the time of service. I understand that I will be given receipts. Should my claim be a motor vehicle accident case my therapist will aid in submitting them, but if my claim is denied or there is a 30 day lapse in payment, I will bring my account up to date immediately upon notification.
- I understand that if I am late for my scheduled appointment, I lose privledge to a full treatment. Should the need arise to change or cancel my appointment, 24 hours notice is required or full charges will apply. I understand the need to notify my therpist as someone else in need could utilize my appointment time. Missed appointment fees will not be billed to my insurance company.
- I understand that my therapist is in full respect of my privacy and at any point during a massage, treatment may be stopped by me. I am also welcome to ask questions during my treatment.
- I agree that recommendations given by my therapist are given for the specific purpose to aid in my wellbeing and should be considered and followed.

_____ _____

Signature Date