Consultation Form

Your Name _____

1) Health History: Are you under the supervision of a health care provider for any of the following conditions? If yes, please specify which condition and the date you were diagnosed:

Surgeries: _____
Kidney failure _____
Heart failure _____
Arrhythmia _____
High blood pressure_____
Stroke _____
Diabetes _____
Cancer _____
Osteoporosis _____
Varicose veins_____
Thrombophlebitis _____
Blood disorders _____
Gynecological disorders _____

Aneurysm _____
Arteriosclerosis _____
Allergies _____
Skin disorders _____
Asthma _____
Autoimmune disorders _____
Thyroid disorders _____
Psychiatric illness _____
Depression, anxiety _____
Fever_____
Pregnancy _____
Fresh injuries _____
Other_____

2) **List current medications you are taking** (including vitamins and herbs)**:** _____
_____
_____

3) **Please specify your current concern** (pain, stress, etc): _____

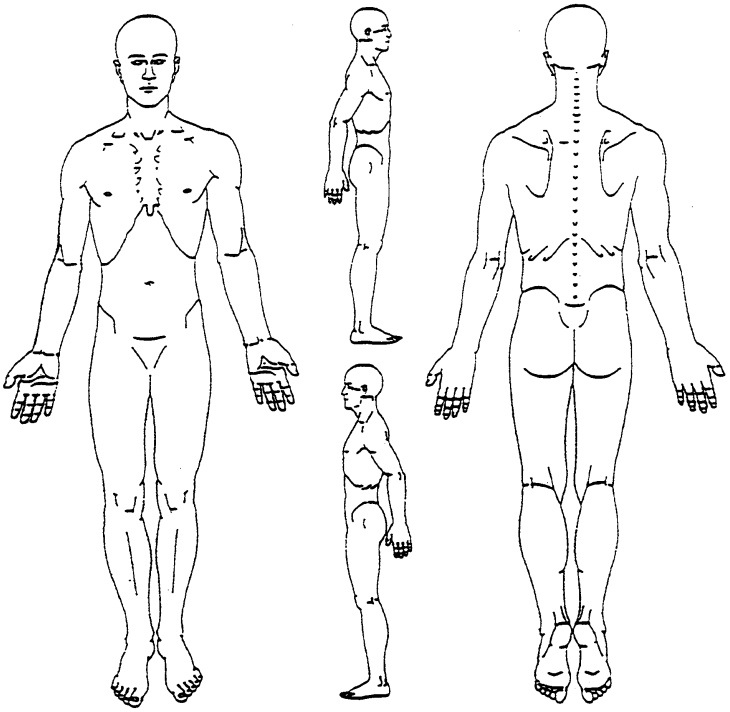
a. How severe is your concern? (circle one):
1 2 3 4 5 6 7 8 9 10

b. Nature of pain: *Sharp____, Dull ___, Shooting___, Burning___, Cramping___, Stabbing___, Other* _____

c. How long have you experienced this concern?
_____

d. Concern is aggravated by: *Heat*_____, *Cold* _____, *Rest*_____, *Activity*_____, *Other* _____

e. Concern is alleviated by: *Heat*_____, *Cold* _____, *Rest*_____, *Activity*_____, *Other* _____



f. Location of problem (use picture)

I affirm that the above information is true and correct to the best of my knowledge. I understand that I am responsible for any damages or injuries resulting from my failure to provide accurate information about my health status.

Your Signature: _____ **Date:** _____

Therapist: _____