Blue Ridge Wellness

Personal History

The information provided by you will be treated confidentially.

Full Name _____ Birthdate _____ Telephone _____
Address _____ City _____ State _____ Zip _____
Occupation_____ Referral Sources: _____
Email _____
Bodywork history (frequency, types) _____
_____
Current discomforts - any specific need or condition for this session? Movements limited?
_____
_____
What do you want/expect? Do you believe it's possible? _____
Time willing to invest in the solution _____
Current practices, how often – yoga, exercise, meditation, prayer, etc. _____
_____
Is it difficult for you to lie on your front, back or side? _____
Hours of sleep per night ____ Bowel movements per day ___ Smoking? ___ Yes ___ No___Amount
Alcohol? ___ Yes ___ No_____Amount Caffeine? ___ Yes ___ No_____Amount
List diet restrictions _____

Past and present medical conditions (please circle):

Allergies	Immune System	Low/Hi Blood Pressure	Pregnancy(s)
Arthritis	Herpes	Bruising	Depression
Carpal Tunnel	Contagious Disease	Varicose Veins	Insomnia
Joints	Digestion	Phlebitis	Dizziness
Spinal Conditions	Constipation	Liver Problems	Seizures
Skeletal Injuries	Abdominal Pain	Diabetes	Other
Muscular Injuries	Chest Pain	Candida	
Fibromyalgia	Respiratory System	Cancer	
Skin Conditions	Circulatory System	Reproductive System	
Nervous System	Heart Disease	PMS	

Do you wear: _____ contact lenses ____ dentures _____ hearing aid ____ prosthesis
Are you under medical supervision? ___ Yes ___ No If so, for what? _____
Are you taking medication? ___ Yes ___ No If so, please list? _____
Emotional difficulty: _____
Do you experience stress? ___ Yes ___ No If so, how much? ____ Little ____ Average ____ Great amounts. If so, from what? _____
What uplifts you, makes you feel whole, connected? _____

I have requested treatment and confirm that the above information is correct. I understand that a massage or yoga therapist does not diagnose illness, disease or any other physical or mental disorder. The practitioner does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. This treatment is not a substitute for medical examination, and it is recommended that I see a physician for any physical ailment that I might have.

Signature _____ Date _____