Personal and Health Information

Name: ____Date: _________

Address: ____

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Home Phone:_____________________ Cell or Work Phone: __________________

E-mail:__________________________

Date Of Birth: _______________ Sex: M F Living Status: Married Single

History of Injuries, Illnesses and/or Surgeries:________________________________

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Regular Physical Activities/Sports: _______________________________________

Circle Any of the Following That You Have or Have Had Within The Past Year:

Pain:	Headaches	Back	Chest	Abdomen	Hip	Leg
	Shoulder	Neck	Arm	Pelvis	Groin	Buttock

Disorders/Conditions:

Allergies	Arthritis	Asthma	Bronchitis	Cancer
Cramps	Depression	Diabetes	Digestion	Emphysema
Epilepsy	Fibromyalgia	Hepatitis	High Blood Pressure	Low Blood Pressure
HIV	Hemophilia	Infectious Skin Condition	Internal Pins Artificial Joints	Phlebitis
Loss of Sensation	Heart Disease	Pregnancy	Pacemaker	Scoliosis
Seizures	Stroke	TB	Vision or Hearing Loss	

Other: ____

Present medications and the condition they are treating: _______________________

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Family Physician: ____

Specialists: ____

Please Indicate Areas Of Discomfort or Tension That You Want Us To Concentrate On:

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How Did You Hear About Apollo Beach Massage Therapy? ____________________