



Please circle any of the following that you are currently taking:

- Laxatives Sedatives Sleeping pills Insulin Blood thinners
- Aspirin Vitamins Herbs Minerals Pain medications
- Ibuprofen / Motrin Acetaminophen / Tylenol Birth control (type? _____)
- Anti-inflammatory medications Anti-anxiety medications Anti-depressants



Are you taking any other medications / supplements at this time? Yes No

Medication/Supplement	Prescribed or over the counter?	For what condition?
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Are you currently under medical supervision? Yes No Physician _____

For what condition(s)? _____

If you have any other medical conditions, such as high blood pressure, allergies, varicose veins, diabetes, phlebitis, cancer, heart condition, infectious/communicable disease, please describe them below.

Condition	Date Diagnosed	Physician/Hospital	Treatment
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Please describe any injuries/surgeries/accidents you have had.

Incident / How did it happen?	Date of Incident	Physician/Hospital	Treatment
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What other information regarding physical conditions / cautions / concerns would you like to share with your therapist? _____

Shooting pains (where? _____) Skin condition / rash (where? _____)
 Stitches (where? _____) Area of inflammation (where? _____)
 Limited range of motion (where? _____) Bursitis (where? _____)
 Implants (where? _____) Prosthetic (where? _____)

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|---------------|------------------|------------------------------|
| Insomnia      | Sleep apnea      | Claustrophobia               |
| Panic attacks | Nervousness      | Irritability                 |
| Depression    | Manic depression | Bi-polar disorder            |
| Schizophrenia | Eating disorder  | Split / multiple personality |

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Please indicate your current level of usage of the following items:

<i>H</i> – heavy	<i>M</i> – moderate	<i>L</i> – light	<i>N</i> – none						
Alcohol	<i>H</i>	<i>M</i>	<i>L</i>	<i>N</i>	Sugared products / sweets	<i>H</i>	<i>M</i>	<i>L</i>	<i>N</i>
Tea	<i>H</i>	<i>M</i>	<i>L</i>	<i>N</i>	Caffeinated beverages	<i>H</i>	<i>M</i>	<i>L</i>	<i>N</i>
Soda	<i>H</i>	<i>M</i>	<i>L</i>	<i>N</i>	Artificial Sweeteners	<i>H</i>	<i>M</i>	<i>L</i>	<i>N</i>
Coffee	<i>H</i>	<i>M</i>	<i>L</i>	<i>N</i>	Wheat flour products	<i>H</i>	<i>M</i>	<i>L</i>	<i>N</i>
Tobacco	<i>H</i>	<i>M</i>	<i>L</i>	<i>N</i>					

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How much water (NOT including coffee, tea or soda) do you drink each day? \_\_\_\_\_ ounces

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- I certify that the above information is complete and accurate. I will keep the therapist informed of any changes as they occur and complete an amendment to my existing health history.
- I understand that: payment is due at the time of treatment unless other arrangements have been made, I am responsible for payment if third party payment is not made, and that a fee will be assessed for a returned (non-sufficient funds) check.
- I agree to give 24 hours notice of cancellation of a scheduled appointment. If less than 24 hours notice is given, I agree that the therapist may charge me for the time of the missed session.
- I understand that neither The Therapy Cottage nor any therapist will be liable for any injuries or loss sustained to myself or to my property while on the premises. In addition, the therapist and The Therapy Cottage’s staff disclaim responsibility for injury sustained while performing exercises or stretches suggested to me. I will not begin exercises or stretches without first consulting my physician.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

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