76 West Main Street
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Hyannis, MA 02601
508-694-6598
Kim@HealingTouchofCapeCod,com
www.HealingTouchofCapeCod.com

Client Information

How did you hear about our business?

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Date________________________

Name____

Mailing Address ____

Phone #: (H) __________________ Cell#: __________________
Email_______________________________

Gender: _____________ Birthday: ___________ Age: _____________

Occupation: ____________________________ Emergency Contact: _____________________

Referred By: __________________________

Reason For Your Visit
Today:____
____

What Is Your Goal For This Visit?

Medical Information

Please list any allergies you may have:

Medications & Purpose:

Have you been diagnosed with a medical condition? (Please, explain & name of Dr. who diagnosed you?)

Have you had any surgeries in last 3yrs? (Please, list)

Have you ever had any broken bones or dislocated joints? (Pleases explain)

Are you being monitored by a Health Care Provider? (Please, explain)

Do you suffer from any of the following medical conditions (Please, check any or all that apply)

High Blood Pressure	Arthritis	Open Wounds
Cancer	Scoliosis	Athletes Foot
Cardiac Problems	Disk or Spinal Problems	Rashes
Asthma	Osteoporosis	Dislocated Joints
Diabetes	Blood Clots	Hyper Flexible Joints
Pregnant	Thyroid Dysfunction	Disc & Spinal
Epilepsy	Low Blood Pressure	Nut Allergies
Athletes Foot	Skin Conditions	Other
Contagious Condition	Varicose Veins	

Please List Any Of Your Concerns:

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Do You Have Any Questions For The Therapist?

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Draw your symptoms on the figure below:

Key:

____

P= pain or tenderness
S= joint or muscle stiffness
N= numbness or tingling

Rate your Pain level: (scale of 0-10- (10) is unbearable)

Are your symptoms limiting or affecting your ability to function normally daily? (Explain) ________________________________

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