HEALTH INFORMATION FORM

NAME:
ADDRESS:
PHONE: EMAIL:

Please check any of the following conditions that apply to you:

	High Blood Pressure		Low Blood Pressure		Poor Circulation to _____
	Glaucoma		Detached Retina		Hiatal Hernia
	Migraines		Headaches		GERD
	Arthritis		Asthma		Allergies
	Fibromyalgia		Sciatica		Pregnancy
	Organ Transplant		Other (list details below)		

Please list any medications that you are on, and for what condition: (Please use the back of this form if you need more room).

	Name of Med:		Condition:

Please check any areas that are painful, weak, or in any way challenged, either occasionally or constantly:

	Low Back		Neck and Shoulders		Hips
	Knees		Hands or Elbows		Other (list details below)

Please provide details for any condition or area you checked. (Please use the back of this form if you need more room). Thank you!

DATE_____ SIGNATURE _____

PLEASE READ AND SIGN THE ATTACHED WAIVER. THANK YOU!