Lotus Transformations

208-882-8534
www.lotus-transformations.com

Name____ Birthday ______________________

Address ____ City__________________

State ______ Zip__________ Phone# H(________)_______________C(_______)_____________

Occupation_____________________________ Referred by _____________________________

email:____

MEDICAL HISTORY **Please mark all that apply**

___Arthritis
___Blood Clots/Varicose veins
___High/Low Blood Pressure
___Recent surgery
___Diabetes
___Cancer
___Asthma
___Neck/spine injury
___Headaches/Migraines
___Back Pain
___Numbness
___Heart Problems
___Pregnant
___Pins/wires/augmentation
___HIV
___Allergies to aromas or lotions
___Stroke

Please explain in detail any conditions marked above__________________________________

____

Please list any medication you are currently taking____________________________________

____

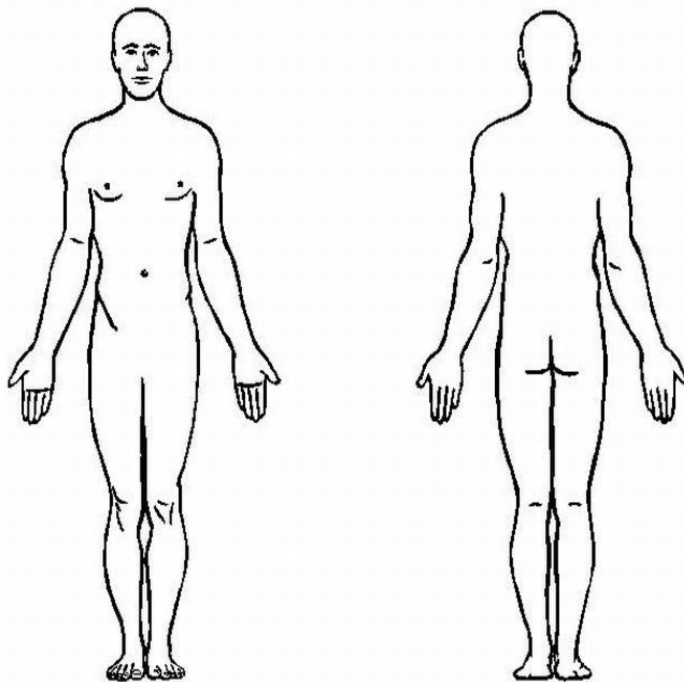
Please describe any other health conditions that I should be aware of_____________________

____

Insurance information:
Insurance company name: _________________________ Policy number: _____________

Note: In order to confirm eligibility and benefits, you will need to present your insurance card at the time of service.

# of Visits_____ # Used_______ Copay_______Deductible ______ Met _____
Referral_______________



Please mark any areas of discomfort you are experiencing today.

On a pain scale of 1-10 (10 being unbearable, 0 being no pain) what level of pain are you feeling?____

Please mark your preferred level of pressure
light_______ Moderate__________ Deep________

Mark all that apply TODAY

___Sunburn ___Cuts, Bruises ___Skin rash
___Severe Pain ___Headache or Migraine ___Inflammation
___Cold/Flu

Emergency Contact
Name ______________________________ Phone Number______________________

Relationship ____________________

I have read the above information and have stated all my known medical conditions. I understand that massage therapy does not diagnose illness, disease or any other physical or mental disorder. **I take it upon myself to update my therapist regarding any changes in my medical condition**.

Clients Signature______________________________ **Date** __________________