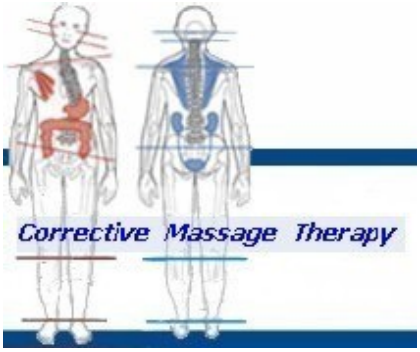


Don Wheeler LMT.
Joleen Kolk LMT
Neuromuscular Therapy

Corrective Massage Therapy

Patient Number:_____
Date of First Visit:_____

Last Name: _____First Name:_____ MI:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Email address: _____
Phone: H (____) _____-_____ W (____) _____-_____ C (___) _____-_____
Other(____)_____-_____ If From Out of town, Local Phone: (____)_____-____
Social Security Number:_____-____-_____ DOB:_____ Age:_____

Sex: **Male_X_** Female___ Height:___' ___" Weight_____ lbs
Marital Status: S____M____D____W_____
Place of Employment:_____
Address:_____
Spouses Name:_____ Spouses
Employment:_____
Phone: (____) _____-____ Other(___)___-____

Who Referred you?_____

How Did you Hear About Us?_____

Habits	Heavy	Moderate	Light	None
Tobacco				
Weekly sugar				
Alcohol				
Coffee				
Tea				
Exercise				

Current Condition:

What Has brought you here today?

_____

List up to five things in order of Priority, that you would like corrected:

(1)_____**(2)**_____ **(3)** _____ **(4)** _____ **(5)**_____

Past History:

Have You had similar problems before? Yes /No If Yes, When?

_____

What caused the episodes?

_____

What do you think relieved them?

_____

Did they disable you? Yes / No Prevent you from working? Yes / No
Hospitalize you? Yes / No
What was previous diagnosis?_____
What were the treatments?_____
Did they help? Yes / No
Name of Physician:_____ Phone(____)_____-_____
Have you ever had any operations? Yes / No
If Yes, describe briefly & give year:_____
Any Broken Bones? Yes / No Which Bones?_____Date_____
Been in an Accident? Yes / No Date:_____
Describe:_____
Constipation? Yes / No How many bowel movements per day?_____ If Yes,
What have you done to relieve it?

_____

To the best of your knowledge, do you have any contagious diseases, *i.e.* HIV,
Harpies, Mono,? Yes / No
If Yes, Which, & What Treatment are you receiving?_____
Do you have any form of cancer? Yes / No If yes, where in the body?_____
List any medications you are currently taking:_____
Has anyone ever told you that you have an anatomically short leg? Yes /
No Fallen Arch Yes / No
Do you wear heal lifts? Yes / No Sole lifts? Yes / No Arch Supports? Yes/ No
Do you use a foam Pillow? Yes / No Feather? Yes / No Orthopedic? Yes /No
Age of mattress:_____ Is your mattress Comfortable? Yes / No
Do you bruise easily? (Black and Blue Marks)_____
Is there anything else you can think of that might help me treat you?

_____

How would it effect your life if you no longer had the condition that brought
you in today?

_____

Would you give me permission to send you an occasional E-mail to check in
on you &/or to let you know about any specials we might be offering?Yes / No

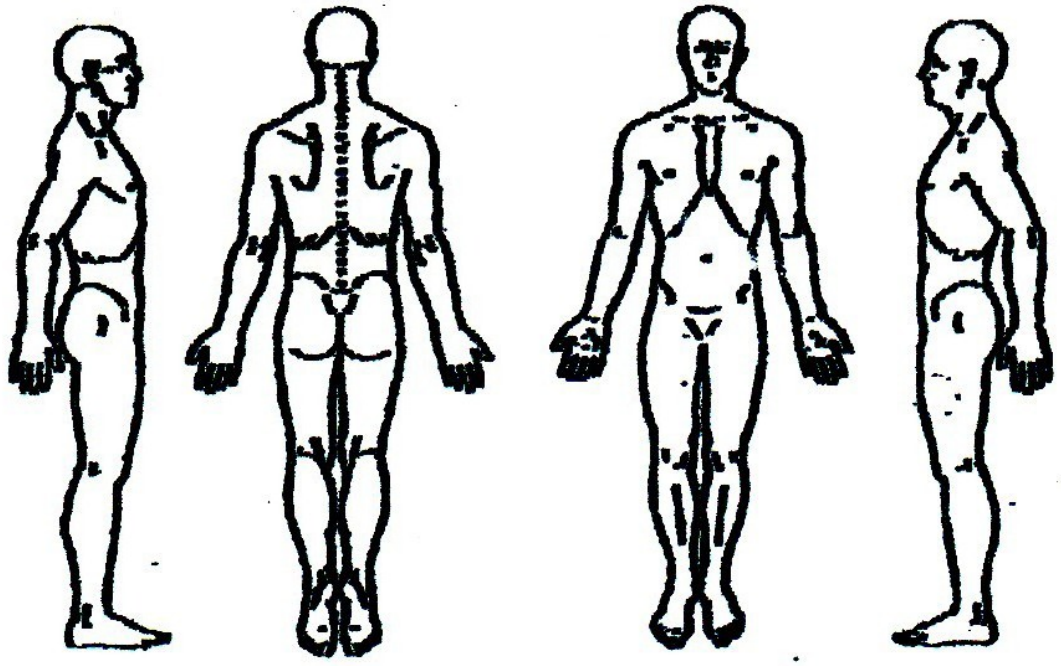
Do You Have Difficulty With Any of the Following:

___Headaches
___Shooting Head Pain
___Sinus Trouble
___Neuritis in Shoulder
___Pins & Needles inArms/Hands
___Loss of Taste
___Tightness in Throat
___Inflamed Throat
___Heart Pain
___Heart Palpitations
___Heart Attacks
___High Blood Pressure
___Low Blood Pressure
___Anemia
___Rheumatic Fever
___Stomach Trouble
___Ulcers
___Nerves or Nervousness
___Inner Tension
___Irritability
___Phlebitis
___Fainting
___Ringing in Ears
___Light Bothers Eyes
___Muscle Spasms
___Grating in Neck
___Tightness of Shoulder Muscle
___Indigestion
___Intestinal Gas
___Cold Hands
___Chest Pain
___Shortness of Breath
___Tuberculosis
___Cancer
___Sleeping Problems
___Painful Joints
___Swollen Joints
___Arthritis
___Slipped Disc
___Pinched Back Nerve
___Pins & Needles in Legs
___Swollen Ankles
___Cold Feet
___Pain in Legs & Feet
___Skin Allergies
___Allergies to Lotion
___Loss of Balance
___Allergies to Oil
___Allergies to Fragrance
___Gall Bladder Trouble
___Thrombosis
___Cold Sweat
___Liver Trouble
___Diabetes
___Loss of Smell
___Hay Fever
___Asthma
___Constipation
___Kidney Trouble
___Bladder Trouble
___Thyroid Trouble
___Face Flushing
___Twitching of Face
___Loss of Memory
___Fatigue
___Depression
___Head Feels Too Heavy
___Dizziness
___Wear Glasses
___Bruise Easily

Male Only

___History of Prostate Trouble
___Urination Difficulty w/Dribbling
___Frequent Night Urination
___Burning Upon Urination
___Persistent Abdominal Pain
___Pain on Inside of Legs or Heels
___Pain in Groin Area
___Tire Easily
___Lack of Energy
___Nervousness
___Excessive Perspiration
___Dizziness
___Diminished Desire
___Burning or Pain During Orgasm

The picture below indicates what areas may be treated during your session. Please indicate areas you feel pain. Also indicate in red which areas to avoid.
In Neuromuscular work, it is important that all ischemic muscles be treated from origin to insertion. This may require treating areas such as the pectoral, gluteus, Quads, adductors, & so forth. I make every effort to keep you informed as to where I'll be treating & why, however, if at any time you feel uncomfortable with any procedure or area being treated, please do not hesitate to tell me, so I can stop, until you are comfortable with the work..
Consent to work areas mentioned above; Yes / No
Normally we will either ask you to wear an exam gown or use a drape, either way you are covered on any area we're not working on.
Your therapy session will consist of Neuromuscular & some Swedish massage.



I hereby certify that the information on this form is true & correct to the best of my knowledge. I understand that massage therapy is not a substitute for medical examination. I agree to pay the therapist for missed appointments. I am responsible for keeping the therapist updated on any changes in my health. I hereby release him from any claims or liability. I understand that if at any time I become uncomfortable for any reason, I may ask that the session be ended.

Patient Signature

Please Note

WHEN YOU MAKE AN APPOINTMENT WITH US , WE START WORKING FOR YOU.

WE RESERVE THAT TIME AND DAY ESPECIALLY FOR YOU , WHICH IN TURN MAKES THAT TIME UNAVAILABLE FOR
OTHERS WHO MAY NEED IT.

WE START WORKING FOR YOU IN ADVANCE BY PULLING YOUR FILES TO REVIEW YOUR SPECIFIC TREATMENTS, X-RAYS,
MEDS, HOMEWORK, ECT.

SO BY THE TIME YOU ACTUALLY COME IN FOR YOUR APPOINTMENT , WE HAVE DEVOTED OUR TIME , ENERGIES AND
OUR RESOURCES INTO YOUR APPOINTMENT.

If we Do Not Receive 24 hr. Notice of your cancellation You Will be Charged for the Appointment

IF YOU ABSOLUTELY MUST CANCEL OR RESCHEDULE YOUR APPOINTMENT,
KINDLY GIVE US AS MUCH NOTICE AS POSSIBLE.

We hope You understand That without 24 hr notice of your cancellation we will have to Charge You for the appointment.

~Thank you for Your Consideration~

I have read this form and agree to the terms therein.

Signature: _____ Print Name: _____