

Please check any of the following conditions you presently experience or have so in the past, please add comments if needed. Thank you!

Musculoskeletal	___Raynaud's Disease	___Bell's Palsy
___Cysts _____	___Varicose Veins	___Parkinson's Disease
___Bursitis _____	___Lymphedema	___Numbness _____
___Gout	___Stroke	___Epilepsy
___Thoracic Outlet Syndrome	___Heart Condition _____	___ALS
___Hip/Leg Pain _____	___Other _____	___Other _____
___Back Pain _____	Digestive	Other
___Headaches/Migraines	___Irritable Bowel Syndrome	___Depression
___Spasms/Cramps _____	___Crohn's Disease	___Fibromyalgia
___Sprains/Strains _____	___Gallstones	___HIV/AIDS
___Arthritis _____	___Colitis	___Cancer _____
___TMJ/Jaw Pain	___Ulcers	___Diabetes, Type: ___
___Scoliosis	___Hepatitis _____	___Eating Disorder _____
___Osteoporosis	___Diarrhea/Constipation	___Chronic Fatigue
___Carpal Tunnel Syndrome	___Bloating/Intestinal Gas	___Anxiety/Panic Attacks
___Tendonitis _____	___Other _____	___Lupus
___Whiplash	Skin	___Thyroid Problems _____
___Neck/Arm/Shoulder Pain	___Eczema _____	___Drug use _____
___Other _____	___Psoriasis _____	___Caffeine use _____
Respiratory	___Rashes/Warts _____	___Alcohol use _____
___Allergies _____	___Herpes/Shingles	___Nicotine use _____
___Pneumonia	___Open Sore _____	___Surgeries _____
___Asthma	___Infection _____	___Other _____
___Sinus Problems	___Impetigo	
___Shortness of Breath	___Athlete's Foot	Medications/supplements:
___Other _____	___Other _____	_____
Circulatory	Nervous System	_____
___Hemophilia	___Multiple Sclerosis	_____
___Hyper/Hypotension	___Sciatica	
___Blood Clots	___Seizures	

I have stated all my known conditions and will update my practitioner of any changes in my health. I understand that bodywork services are not a replacement for medical care and that the practitioner cannot diagnose. I agree that payment is due at time of service and I agree to give at least 24 hours notice of appointment cancellation. I understand that Yvonne Vasquez, LMP will assist me in billing my insurance carrier. However, I am fully responsible for any payments due that are denied by my insurance carrier.

Signature

Date

Yvonne Vasquez, LMP MA00023961
202 12th Ave E Seattle WA 98102 t: (206) 229-7412
cultivate mind-body awareness. nourish your health. facilitate movement. explore the present.

Date: _____

Name: _____ Sex: __ F __ M DOB: _____

Address: _____

Phone: _____ Email: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referred by: _____

What is the primary reason for your visit today? _____

Please share your expectations for today's bodywork session? _____

Are you aware of having any tension, pain, stress today? If so, please describe? _____

Please list any accidents, surgeries, injuries you have had: _____

Are you under the care of any other health care professionals? _____

Please describe the activities involved in your occupation: _____

Please describe your exercise habits: _____

What brings you joy? What hobbies/activities do you enjoy? _____

Please share your goals towards your health and well being? _____

When was your last massage? How often do you receive bodywork? _____