



SOLÉ MEDICAL SPA
PATIENT INFORMATION FORM

Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State / Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Contact: _____ Relationship: _____

List 2 phone numbers for emergency contact: _____

Would you like to be added to our Email, Newsletter, and Special Offers List? Yes / No

May we send correspondence to your home address? Yes / No

How did you hear about us? _____

List all previous Hospitalizations / Surgeries / Serious injuries Dates

List all current medications (include prescription, OTC, supplements, etc.) _____

Do you have or have you had any of the following conditions? (answer Yes or No)

____ Fatigue

____ Seizures or Convulsions

____ Fever

____ Tingling Sensations

____ Eye Problems

____ Depression

____ Ear Problems

____ Heat or Cold Intolerance

____ Sinus Problems

____ Easy Bruising

____ Breathing Problems

____ Hyper/Hypotension

____ Constipation / Diarrhea

____ Heart Conditions

____ Joint Pain

____ Blood Clots

____ Back Pain

____ Athletes foot

____ Headaches

____ Fungal Infection

____ Neck Pain

____ Other _____

Dizziness

Please explain any condition listed above (include date of diagnosis, recovery date, etc.)

What is your previous experience with massage therapy? _____

Signature: _____ Date: _____