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
_____Fever
_____Eye Problems
_____Ear Problems
_____Sinus Problems
_____Breathing Problems
_____Constipation / Diarrhea
_____Joint Pain
_____Back Pain
_____Headaches
_____Neck Pain
Dizziness

_____Seizures or Convulsions
_____Tingling Sensations
_____Depression
_____Heat or Cold Intolerance
_____Easy Bruising
_____Hyper/Hypotension
_____Heart Conditions
_____Blood Clots
_____Athletes foot
_____Fungal Infection
_____Other_____

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

_____

_____

What is your previous experience with massage therapy? _____

_____

Signature: _____ Date: _____