

Patient Name: _____	Today's Date: _____
Address: _____	Cell: _____
City/State/Zip: _____	Which number is best to reach you? _____
Email: _____	Do you agree to text message appointment reminders? YES NO
Date of Birth: _____	Marital Status: (Circle)
Age: _____	Single Married Divorced Other
Height: _____ Weight: _____	Name of Spouse: _____
Employer's Name: _____	Spouse's Employer: _____
Job title: _____	
Type of Work: _____	

Name and Phone Number of your nearest adult relative: (emergency use only)

Purpose of this appointment: _____

Doctors you have seen for this condition: _____

Type of treatment: _____ Results: _____

When did this condition begin? _____. Has it occurred before? YES NO

Are you taking medications YES NO * If YES, please circle the ones you are taking:

Muscle Relaxants	Anti-Inflammatory	Narcotics for Pain
Heart Medications	Aspirin	Tylenol/Advil/Motrin

Other: _____

Injuries/Surgeries: _____

By Signing Below, I Understand: (please initial)

_____ Message is not a replacement for medical care and no diagnosis will be made.

_____ If I need to cancel an appointment, I agree to give Micki Beach 24 hours notice in order to offer the session to another client. Otherwise, I understand I will be invoiced for the full session.

I, for myself and my heirs, attest to fully release and discharge Micki Beach, Tree of Life, it's respective directors, employees and instructors from all liability, claims and demands or actions that I may make resulting from injury, death or damages arising from my participation in Tree of Life massage treatment or classes. This includes losses caused by negligence of the released parties.

Date	Signature
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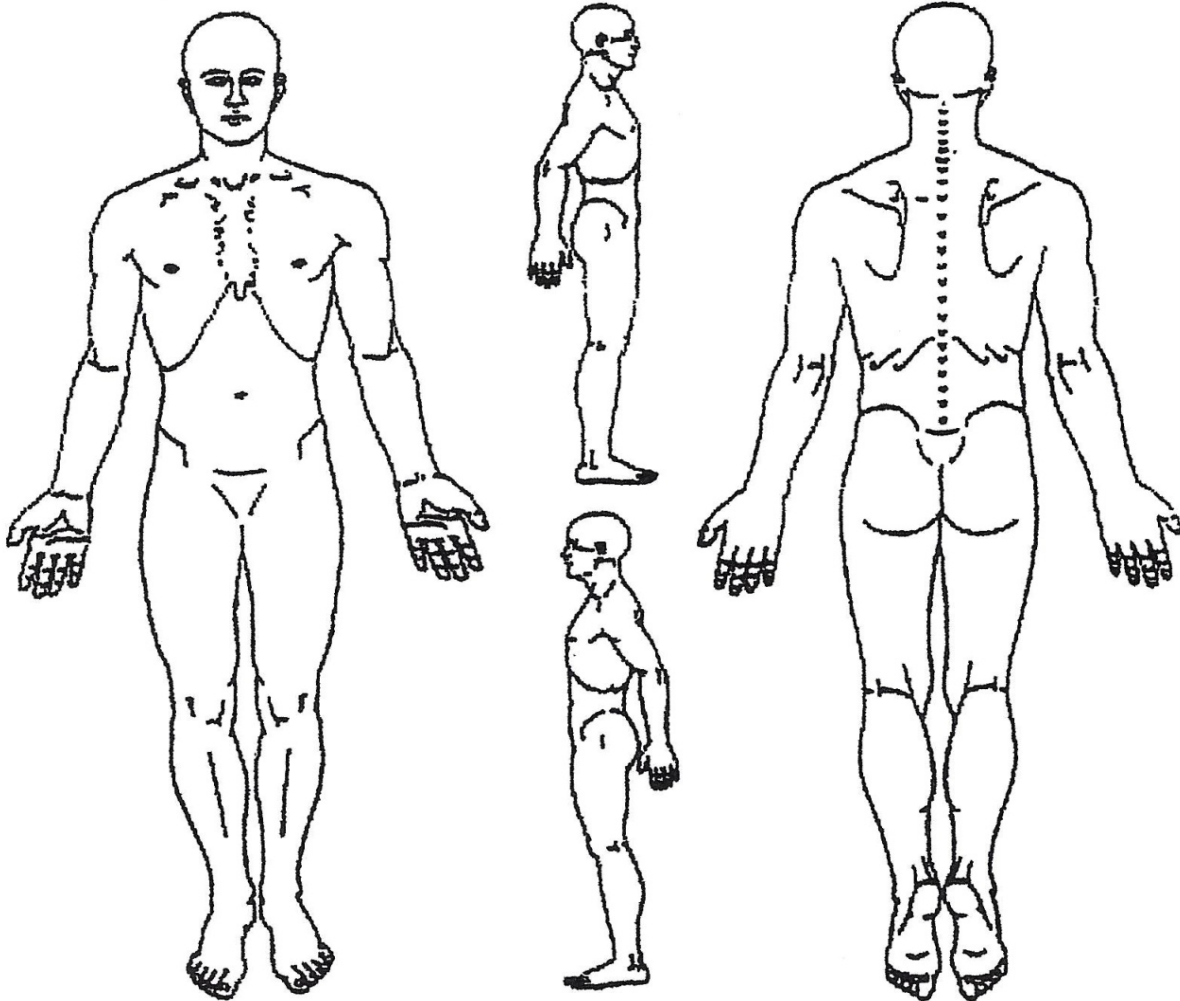


MICKI BEACH
E-RYT, RYS
Tree of Life Yoga Studio . est. 2011
Group and Private Yoga Classes
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phone : 910-366-3664



Please draw location of your pain or discomfort on the image below.
Use the symbols shown to represent the type(s) of pain:

D = Dull	S = Stabbing/Cutting
B = Burning	T = Tingling (Pins & Needles)
N = Numb	C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right now:

No Pain | Unbearable Pain

|-----|

Rate your pain at its best in the past week:

No Pain | Unbearable Pain

|-----|

Rate your average pain in the past week:

No Pain | Unbearable Pain

|-----|

Rate your worst pain in the past week:

No Pain | Unbearable Pain

|-----|



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