Popiel Holistic Therapy

Confidentiality of personal information is respected and secured.

Name: _____ Date of Birth: _____

Address: _____

Phone: Primary _____ Cell _____ E-mail_____

Emergency Contact/Relation: _____ Phone: _____

Lifestyle and Healthcare Information

Occupation/Grade in School: _____
Hobbies/Recreation: _____
Hours of sleep nightly/sleep patterns: _____
Coffee/Tea/Caffeine intake: _____
Tobacco use: _____
Allergies (Medications/Foods/Environmental): _____

Medications/Supplements: _____

Existing Medical Conditions: _____

History of Surgery: _____

Do you have cardiac or circulatory problems? _____

Have you ever had any broken bones, dislocated joints, or joint replacements? _____

Have you ever had surgery or treatment for eye conditions? _____

Are you pregnant? _____

Are you sensitive to touch/pressure in any area? _____

Are you currently experiencing pain or tension in any area? Please give details? _____

Personal Responsibility Statement: I have addressed the above information to the best of my knowledge and agree to inform my practitioner of any change in my medical profile including changes in medication.
I understand that Holistic Body Therapy is not a substitute for medical examination, diagnosis and treatment though it is frequently received as a complement/support to conventional medical care.
I understand that cancellations are requested 24 hours prior to appointment times.

Signature: _____ Date: _____

Thank you! Susan