PURA VIDA HEALTHCARE
a holistic cooperative

Confidential Health Questionnaire
DeVere Gamble
Massage & Cranio-Sacral Therapies

Name: _____ Date: _____

Address: _____

City, State & Zip: _____

Phone: _____ DOB: _____

E-mail: _____

Reason for visit: _____

_____

How did you hear about me? _____

What kind of exercise/ Occupation? _____

_____

_____

Emergency Contact: _____ Phone: _____

Circle the symptoms that apply to you:

Allergies Diabetes Arthritis Scoliosis Headaches Weakness
Indigestion Sciatica Low or high blood pressure Insomnia Fatigue
Cardiovascular Numbness Respiratory Skin sensitivities/rashes
Other: _____
Taking any medications? _____
Any surgeries in the last two (2) years? (If yes, indicate what and when.) _____

_____

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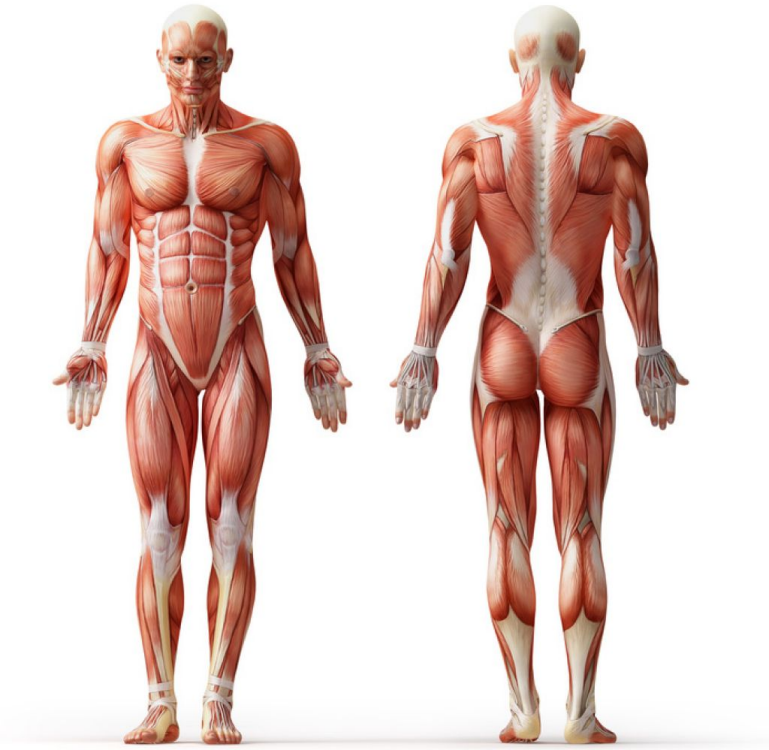
Mark any body parts where you are experiencing discomfort or pain:



By signing this statement I acknowledge and understand that the treatment I am about to receive is in the best interest of my needs and wellbeing. I hereby take full responsibility for myself and consent to allowing the therapist to perform her treatment. The Massage Therapist performing the treatment is doing so within her scope of practice. In case she is not able to help me she will refer me to someone who can better suit my needs.

Signature: _____ Date: _____

Cancellation Policy: I understand that it is my responsibility to cancel an appointment 24 hours before its scheduled time or be charged the full amount of my scheduled visit.

Signature: _____ Date: _____