Colleen Leigh LMT

Expert Level MFR Therapist

Treehouse Wellness Studio

1141 Pacific Suite C SLO

(805)550-4449

Name_____ **Date**_____

Age_____

Address_____

Phone #_____ **Cell #**_____ **Text?**_____

Email_____ **Occupation**_____

Emergency contact_____

How did you hear about Colleen_____

What is your primary complaint?_____

Secondary complaint?_____

How and when did your symptoms begin?_____

_____

_____

_____

_____

_____

_____

_____

Have you received any other treatment for your current symptoms?_____

_____

Below is a list of common activities. How long can you do these activities until you need to stop because of symptoms?

If you can do activity write YES, if unable write NO.

Sitting_____Standing_____Walking_____Sleeping_____Bending_____

Household Chores_____Computer work_____Exercise_____Other_____

Put an X on the line below to rate INTENSITY of your symptoms right now:

No pain_____worst pain

Put an X on line below to indicate the frequency of your symptoms:

No pain_____constant pain

What are your goals for treatment?

_____

_____

_____

_____

What activities would you like to feel better doing?

_____

_____

Circle those that apply:

Circulatory problems	**Pregnancy**	**Cancer**	**Stroke**
High/Low Blood Pressure	**TMJ Issues**	**Headaches**	**Migraines**
Ringing in ears	**Diabetes**	**Epilepsy**	**Heart Issues**
Bowel/Bladder issues	**Sleep issues**		

Medical history: please list surgeries, accidents, and traumas with approx. date:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list medications:

_____
_____

Anything else you would like to share that would help in your treatment?

_____
_____
_____
_____