Nina Capobianco, LMT, CMLDT
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45 Lyman St Suite 22 Westborough, MA 01581
The Healing and Wellness Center at Chauncy Place
Phone 508-241-2110
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Client General Health History

Full Name: ____

Date: _____________

Cell phone: ____

Email Address: ____

Address: ____

City: __________________________

State: ______

Zip: ____________

Occupation: ____

Age: ________

DOB: __________

Have you had any form of bodywork before? Yes / No

What is the amount of stress/anxiety in your life? 0….1….2….3….4….5….6….7….8….9….10
(none) (average) (extreme)

What physical activities do you do on a daily or weekly basis?

____

Please circle any painful or tense areas that you tend to hold your stress:

Head/Face	Low Back	Shoulders	Neck	Abdomen
Legs/Feet	Arms/Hands	Mid-back	Other: ______________________________	

Are you currently under a Physicians care for a specific condition? Yes / No

If yes, for what condition(s)? ______________________________________

Have you recently (within 18 hrs) taken any medications or drugs that alter sensation?
(e.g pain medication, muscle relaxants, alcohol or other depressants or stimulants)

____

Have you had any of the following health issues in the past year?

Allergies: ______________________________________

Angina

Asthma

Blood Clots

Cancer

Carpal Tunnel Syndrome

Communicable diseases

Disk Problems

Fibromyalgia

Heart Disease

Hepatitis

Herpes Simplex

Hospitalization

Hypertension

TMJ or tendency to grind teeth

(Auto)Immune system conditions

Irritable Bowel Syndrome

Insomnia

Migraines / Headaches

Phlebitis / Thrombosis

Repetitive Strain Injuries

Sciatica

Stroke

Surgery

Varicose Veins

Whiplash Other: ______________________________________

GENERAL MEDICAL SIGNS AND SYMPTOMS:

Symptom:	Yes	No	Comments
1. Any areas of infection?			
2. Any areas of swelling, edema or tendency to swell?			
3. Any areas of numbness or altered sensation?			
4. Any areas of pain or tenderness?			

SPECIFIC CONDITIONS:

Condition:	Yes	No	Comments
5. Arthritis			
6. Cancer or Tumors			
7. Cardiovascular Diseases			**Circle all that apply**: Anemia, Angina, Arteriosclerosis, Congestive Heart Failure, Heart Attack, Heart Murmur, Hemophilia, Hypertension, Varicose or Spider Veins, Other: _______________
8. Diabetes			
9. Injuries			
10. Kidney, Liver or Urinary problems			
11. Respiratory Conditions			
12. Skin Conditions			**Circle all that apply**: Acne, Abrasions/Cuts, Bruises, Dermatitis, Eczema, Hives, Poison Ivy/Oak/Sumac, Psoriasis, Sunburn, Warts, Other: _________
13. Surgery			Date of Surgery: Describe:
14. Gastrointestinal Problems			
Other Conditions not mentioned above			

Cancellation Policy

Out of respect for Nina's time and others that might be waiting for an appointment, please give at least 24 hrs notice if you must cancel an appointment. The full service fee will be charged with less than 24 hr notice or if you do not show up, emergency situations excluded.

Printed Name ____

Signature ____

Today's Date ____