



Medicinal Aromatherapy and Massage

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Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential.

Please print clearly in ink.

Name: _____ Sex: M / F Date: _____

Email: _____

Address: _____ City: _____ State: _____

Zip: _____

Date of Birth _____ Age _____

Telephone: Home () _____ Work () _____

Cell () _____ Emergency Contact: _____

Occupation: _____

Referred by: _____

Reason for visit today:

Other problems

How long have you had this condition? _____

Have you ever experienced this before? _____

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

Does it bother you : Sleep ____ Work ____ Other
(what?) _____

Describe the exercise activities you do (include frequency):

List other therapies you receive:

MEDICINES:

Prescription drugs you are currently taking and for what condition?

Over-the-counter medication you are currently taking and for what condition?

MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious medical illness or operation,

write the most recent one below: (do not include normal pregnancies).

Year Operation/illness _____

Have you ever had massage or bodywork before? Yes | No

If so, Where? _____

Please Indicate with an **X** where on your body you feel discomfort and/or pain.

