Tanya L. Colucci, MS, LMT
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Medical History Disclosure Form

Name: _____Age & Date of Birth: _____
Emergency Contact:_____
Email Address: _____ Phone Number:_____

What areas of the body *(i.e. Neck, Left hip, Right Shoulder, etc.)* or conditions *(i.e. Fatigue, Arthritis, etc)* are you currently seeking care for?

If there are multiple areas of involvement, which region/problem is of greatest concern at this time?

Have you ever been treated for this same problem before?
If so, when & who treated this problem (i.e. 1999 by John Smith, DC & Jane Jones, MSPT)?

Did prior treatment successfully manage or resolve the problem at that time?

Please circle any/all illnesses you've either had in the past or currently have:

Cardiovascular disease	Asthma/Breathing difficulty	Hepatitis/Liver disease	Depression
High Blood Pressure	Congestive Heart Failure	Epilepsy/Seizures	Anemia
Diabetes (I or II)	Multiple Sclerosis	Thyroid condition	Osteoporosis
Stroke or Heart Attack	Fibromyalgia	Neurological condition	Chronic infections
Arthritis (Osteo/Rheum)	Migraines/Headaches	Eating disorder	Lupus
Kidney/Renal disease	Dizzy/Vertigo	Drug or Alcohol abuse	HIV/AIDS

Cancer (Type _____; Location(s) _____; Year _____
Status _____)
Other: _____

Do you have a pacemaker, internal defibrillator, insulin pump, metal fixator, or any other implanted medical device?

Please list all prescription medications you are presently taking & reason for medication *(i.e., Prozac for Depression, Percocet for pain, Accupril for High Blood Pressure):*

Are you currently pregnant or is there even a possibility you might be pregnant?

List all daily activities that you do to nourish your mind, body, and spirit? (exercise, meditation, prayer, creative pursuits, etc)

What type of emotional & physical trauma have you experienced in your life? *(Death of loved one, sexual abuse, emotional abuse, accidents, etc)*

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Where do you feel blocked and not in alignment in your life?

Where do you currently feel aligned in life?

Do you want to experience more joy?

Are you ready to release all fears holding you back? What specific fears do you have?

In what areas of your life are lacking fulfillment?

What do you desire?

Anything else that you feel I should know?

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE & TRUE. IF MY MEDICAL/HEALTH STATUS CHANGES I WILL INFORM YOU IMMEDIATELY.

Signature & Date: _____

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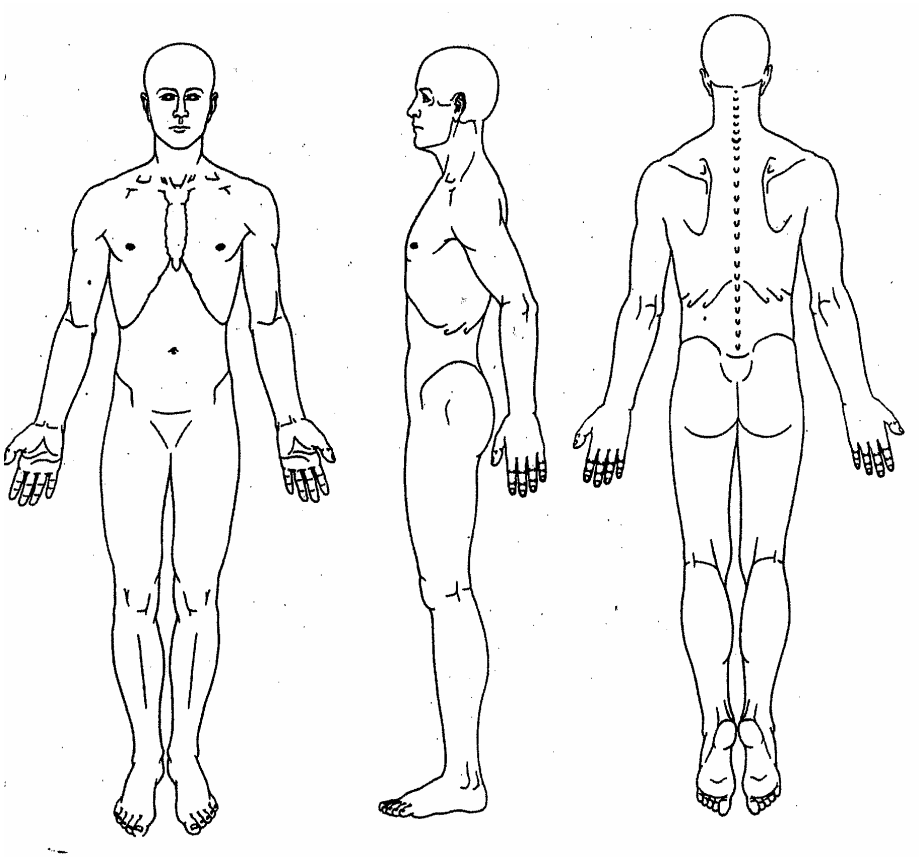
Please mark the body diagrams with the following letters to indicate what you have been recently experiencing:

P = Pain; T = Tightness; N = Numbness/Tingling; W = Weakness.



Next to each letter, please write a corresponding number (0 through 10) that conveys the intensity of your experience.

0=No pain, 10=Emergency Room pain)