



Theron Eirish

Massage and Personal Training
(360) 303-8992

HEALTH HISTORY: (Check all that apply)

MUSCULO-SKELETAL

- ____ Bone or Joint Disease _____
- ____ Tendonitis _____
- ____ Bursitis _____
- ____ Broken/Fractured Bones _____
- ____ Sprains/Strains _____
- ____ Low Back, Hip, Leg Pain _____
- ____ Neck, Shoulder, Arm Pain _____
- ____ Headaches/Head Injuries _____
- ____ Spasms/Cramps _____
- ____ Jaw Pain _____
- ____ Lupus _____
- ____ Other _____

CIRCULATORY

- ____ Heart Condition _____
- ____ Varicose Veins _____
- ____ Blood Clots _____
- ____ High Blood Pressure _____
- ____ Low Blood Pressure _____
- ____ Lymph edema _____
- ____ Breathing Difficulty _____
- ____ Sinus Problems _____
- ____ Allergies _____
- ____ Other _____

INFECTIOUS DISEASE

- ____ Disease Names _____

SKIN

- ____ Allergies _____
- ____ Rashes _____
- ____ Athletes Foot _____
- ____ Warts _____

DIGESTIVE

- ____ Constipation _____
- ____ Gas/Bloating _____
- ____ Diverticulitis _____
- ____ Irritable Bowel syndrome _____
- ____ Other _____

NERVOUS SYSTEM

- ____ Herpes/Shingles _____
- ____ Numbness/Tingling _____
- ____ Sleep Disorders _____
- ____ Other _____

REPRODUCTIVE

- ____ Pregnant? Stage _____
- ____ PMS _____

OTHER

- ____ Cancer/Tumors _____
- ____ Diabetes _____
- ____ Eating Disorders _____
- ____ Drug/Alcohol addiction _____
- ____ Nicotine/Caffeine Addiction _____

It is my choice to receive massage therapy. I understand that massage practitioners do not diagnosis illness, disease, or any physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge massage is not a substitute for medical examination, and it is recommended I see a primary health care provider for this service.

By signing below I authorize all insurance payments to be made directly to Theron Eirish LMP. I understand my signature allows the release of my medical records to my "first party" payer identified above as necessary to have my bills paid. I understand that my primary insurance company will be billed directly on my behalf for these massage sessions as a courtesy. I agree to take full responsibility for any remaining balance not paid by my insurance company or related companies, including co-pays, deductibles, non-covered services, and denied services. If the treatment is for injuries sustained in an auto accident where payment is pending from a "third party" I understand that my full cooperation will be necessary to secure payment from that "third party". In the event that no payment is made, I will be held fully responsible for the charges incurred. This signature may be used for submitting all insurance claim bills.

Signed _____ Date _____