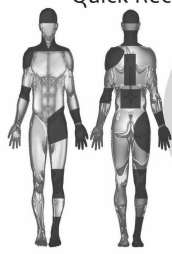


Health form: # [REDACTED]

FastTrack Pain & Mobility SOLUTIONS

Quick Recovery for Performance and Function



Twin Palms Massage Therapy
Balancing your Mind, Body, and Spirit.

Eric Goodbar (540) 580-1231
Advanced Drug Free Therapy 5720 Williamson Rd # 101
Rossiter System® & Massage Roanoke, VA 24012
www.TwinPalms.MassageTherapy.com

Today's date _____

Name _____

Address _____

City _____ State _____ Zip _____

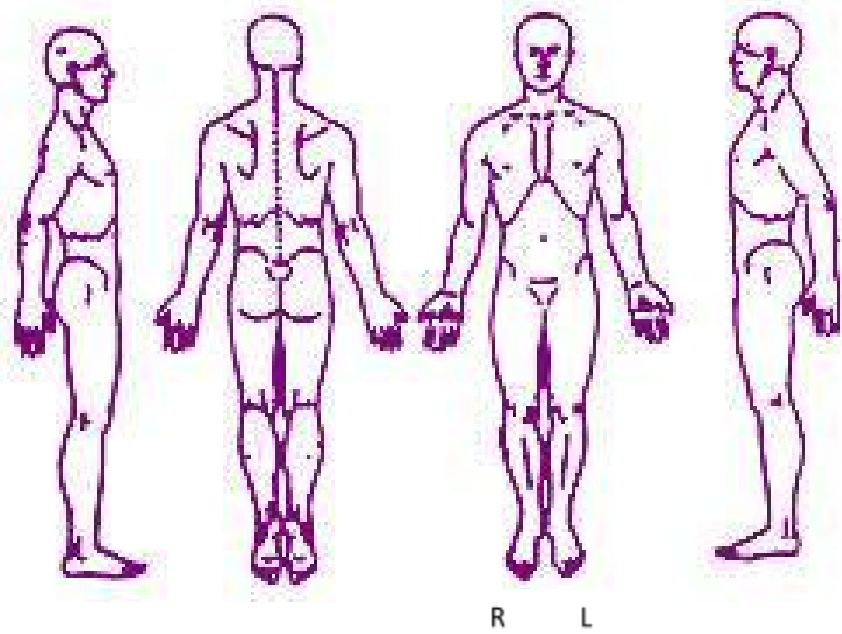
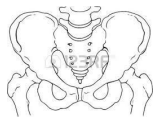
Email _____

Phone H _____ W _____ C _____

Date of Birth _____ Occupation _____

Referred by _____

Place an "X" in the areas on the figures below where you currently have pain, discomfort, or range of motion restriction.



What area of the body would you most like to have felt better today? _____

Rate the level of pain, discomfort, or range of motion restriction for this area.

Less Pain/stiffness [0 1 2 3 4 5 6 7 8 9 10] More Pain/stiffness
(Please circle)

1. Have you ever **broken any bones**? _____ No _____ Yes (please explain) _____

2. Are you currently under any **medical supervision**? _____ No _____ Yes (please explain) _____

3. Are you currently taking any **medication**? _____ No _____ Yes (what for) _____

4. Have you ever had any **surgery**? _____No _____Yes (please explain) _____

5. Have you ever had any **cortisone injections**? _____No _____Yes (please explain) _____

6. Have you ever had any **serious injury or accident**? _____No _____Yes (please explain) _____

7. Do you have any **hardware, implants, or patches** in/on your body? _____No _____Yes (please explain) _____

8. Have you had **cancer, osteoporosis**, or any other major medical condition? _____

9. Do you have any other **medical condition**, physical illness or limitation that I need to be aware of? _____No _____Yes (please explain) _____

I understand that this bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. I am responsible for consulting a qualified physician for any ailment that I have:

I have or have had cancer. It's my body and my choice to proceed with the bodywork and I do not believe it would cause cancer or make it worse. I am completely responsible for any outcomes, good or bad from each workout.

I have had **cortisone shots OR surgery in my low back for low back pain.** It's my body and my choice to proceed with this bodywork for my low back pain. I am completely responsible for any outcomes, good or bad from each workout.

RESCHEDULING & NO SHOW POLICY:

I am holding a specific time for your session to help your body feel and function better. Please remember I have a 24-hour rescheduling policy, so if you decide your scheduled time won't work for you, please be sure to let me know at least 24 hours before your appointment. Any changes within that 24-hour window OR if you don't show up you will have a \$20 rescheduling fee OR no-show fee. This fee is subject to change over time.

I agree to the rescheduling & no show policy.

Signature

Date

PRACTITIONER/ COACH ONLY:

Primary concern _____ Date _____

techniques used _____

Additional Feedback _____

Date _____ Feedback since last visit _____

Primary concern _____

techniques used _____

Additional Feedback _____