# Zoe Eves-Cowell Myotherapy & Dry Needling. Health History/Consent Form

Name _____ DOB _____Phone _____

Address _____Post code_____ State _____

Occupation _____ Email _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us_____

## Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Ladies are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high-risk factors? _____

Do currently suffer from pain? ☐ yes ☐ no

If yes, please explain _____

Have you had any injuries Past/present? ☐ yes ☐ no

If yes, please list: _____

_____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis (OA or RA)
☐ Diabetes T1 or T2
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains

Explain any conditions you have/have not marked above

_____

## Treatment Information

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

Are there any areas (feet, face, abdomen, etc.) you do not want treated? ☐ yes ☐ no

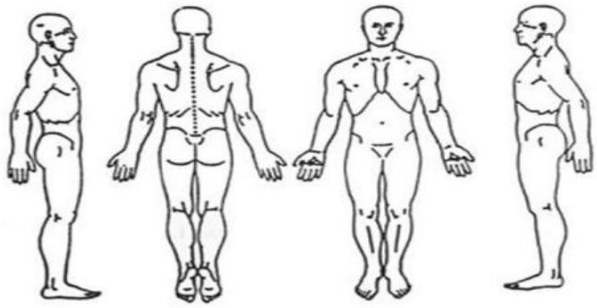
Please explain _____

What are your reasons for seeking treatment?

_____

_____

Please indicate/circle any areas of current discomfort



*Use space below for any additional information*

_____

*By signing below, you agree to the following.*

*I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.*

*Client Signature* _____ *Date* _____

*If you're under the age of 18 or unable legally to consent, your parent/guardian must sign and date the new client form.*

*Parent/Guardian Signature* _____ *Date* _____