

TEDI ZIMBECK, RMT ~ Relaxation and Soft Tissue Rehab ~ ReSToRe LLC.

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This questionnaire has been designed to assist in providing you the best professional care. This information will be kept in confidence.

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

HomePhone: _____ Work/ Cell: _____ Occupation: _____

Birthdate: _____ How did you hear of me? _____

What kind of activities do you do? _____

Why do you want a Massage? _____

Have you had a Professional Massage before? (Yes / No) Describe briefly any recent (or old that still bother you) surgical operations, injuries, broken bones, illnesses: _____

Please describe any medications you are currently taking: _____

Who is your regular health care provider/ MD ? _____

If you are here for pain or injury, rate your level of pain:(no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain)

CHECK IF YOU HAVE HAD RECENT (or CHRONIC) PROBLEMS WITH THE FOLLOWING:

- | | |
|--|--|
| <input type="checkbox"/> Sinus/Allergies | <input type="checkbox"/> Heart Condition - explain _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Numbness/Tingling - Where? _____ |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Area of Inflammation - Where? _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis - Where? _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bursitis - Where? _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Skin Condition/Rash - explain _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Infectious Condition - explain _____ |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Seizure Condition - cause? If known _____ |
| | <input type="checkbox"/> Dizziness/Fainting - cause? _____ |

FEMALES

Pregnant, # of months _____

HEAD/NECK

- Headaches
- How often? _____
- back of head/forehead
- temples
- other _____
- migraines
- Loss of balance/dizziness
- Grind/Clench teeth
- TMJ Dysfunction

SHOULDERS/ARMS

- Can't raise arm overhead
- Shoulder dislocates easily
- Which one? R / L
- shooting/tingling pains
- loss of grip strength

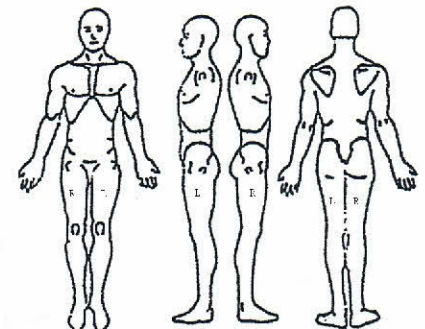
BACK

- Pain/burning between shoulder blades
- previous back injury - Y / N
- where? How? _____
- back surgery - where? _____
- when? _____

HIPS/LEGS/FEET

- Shooting/tingling pains
- Hip/Knee replacement or surgery
- R / L When? _____
- Ticklish/Sensitive feet

OTHER CONDITIONS OR INFO: _____



SIGNATURE: _____

Please circle areas of pain or injury