Dr. Robert S. Kinsella
Butterfly Landing
MEDI-SPA

PLEASE PRINT CLEARLY

Name_____Date_____
Address_____City_____Zip_____
Phone_____ Alt phone _____Occupation_____
Date of Birth_____ email _____
(we occasionally send coupons & news)

Whom may we thank for referring you? _____

Lifestyle

How many hours do you sleep per night? .....How often do you exercise?.....
On a scale from 1 (low) to 10 (high), how would you rate your stress level? .....

Health/Medical

Are you basically in good health?..... Physicians Name / Dermatologist.....
Please list all medications you take regularly. Include hormones, vitamins, etc:
.....
.....
Please list any allergies.....
.....
How much water do you drink daily? .....
Please check any health conditions, which you have had in the *last three years*, or are now experiencing:

- ○Alcoholism
- ○Asthma
- ○High/low blood pressure
- ○Hysterectomy
- ○Lack of Normal Skin sensation
- ○Recent Operation
- ○ Type 1 Diabetes
- ○Heart problems
- ○Nursing
- ○HIV/AIDS
- ○Hepatitis
- ○Claustrophobia
- ○Hormonal disorders
- ○Thyroid Disorders
- ○Multiple Sclerosis
- ○Smoking
- ○Type 2 Diabetes
- ○Cancer
- ○Arthritis
- ○Kidney Disease
- ○Muscular conditions
- ○Epilepsy
- ○Hypoglycemia
- ○Recent Illness_____
- ○Metal Implants_____
- ○Whiplash
- ○Thrombosis or Phlebitis
- ○Pregnancy_____
- ○Chiropractic Care
  - Date of last treatment _____
  - Area Treated _____

If any of the above areas are checked, please provide necessary details:
.....
.....
Comments or additional information we need to know about your health:
.....
.....

FOR MASSAGE CLIENTS ONLY

I understand that Massage Therapy is meant to reduce stress and is not a replacement for a physicians care. Initials_____

** Please proceed to the end of this form and sign at the bottom of back page and return to the receptionist.*