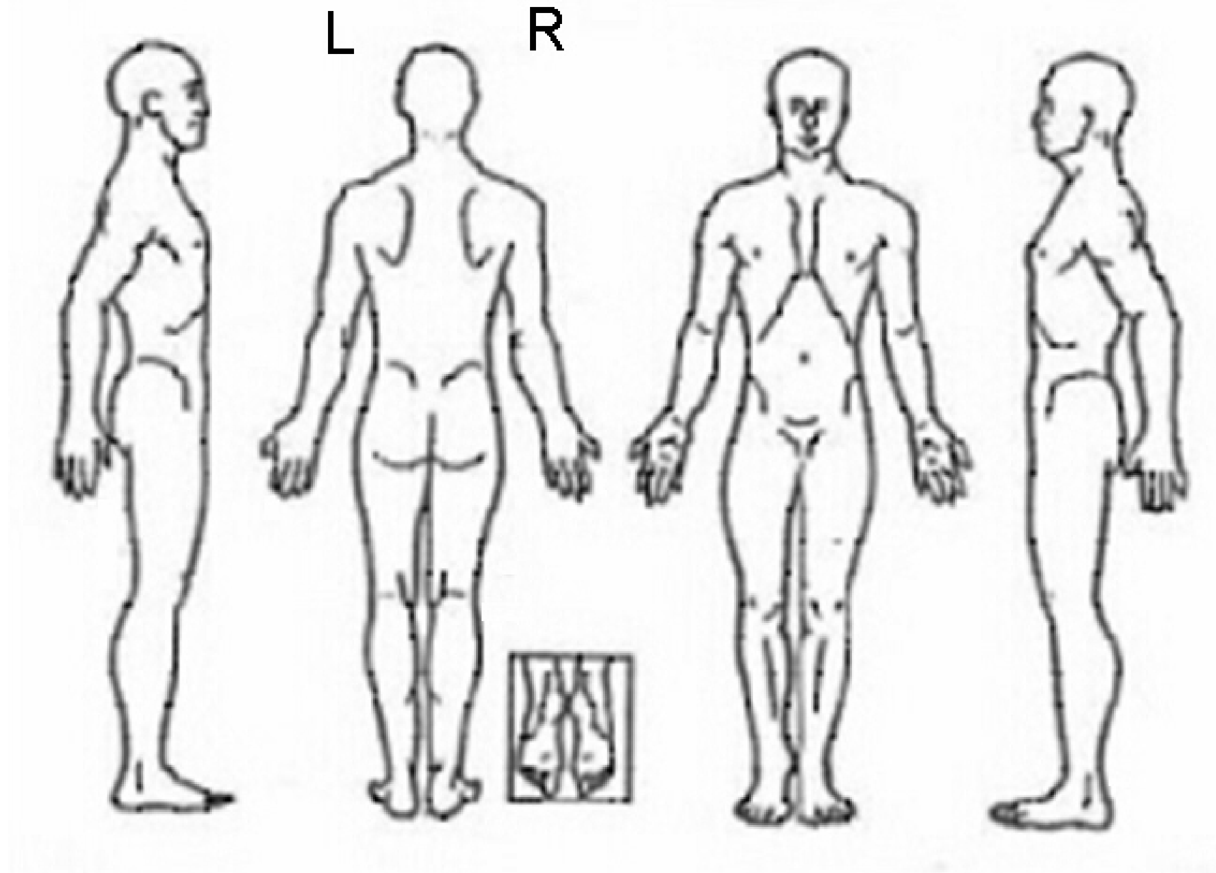
<u>Other diagnosed diseases or conditions</u>: Please check any which apply:

- ☐ diabetes (type 1 or 2)
- ☐ cancer – what and where? __________
____
- ☐ epilepsy
- ☐ hemophilia
- ☐ digestive conditions – what and for how long? __________
____
- ☐ gynaecological conditions – what and for how long? _____
____
- ☐ other: ____

Do you wear glasses/ contact lenses/ hearing aids (Please circle)

On the diagram below, please **CIRCLE** your problem areas.



On the diagram above, please indicate any of the following that may apply, by marking the appropriate code letter to the area: C = cold area; N = numbness (loss of sensation); P /W= surgically implanted pins or wires; A = arthritis; AJ = artificial joints or special equipment.

I verify that the information given is complete and accurate. I understand that the information I give on this form is STRICTLY CONFIDENTIAL. I understand that cancellation of an appointment requires 24 hours notification or full fees may apply. I agree that full fees are due when service is provided.

_________________________ Client signature

_________________________ Date