CLIENT HISTORY FORM

Name:_____ Date:_____

Address:_____ Email:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Height:_____ Weight:_____ Age:_____ # of Children:_____ Occupation:_____

Emergency contact:_____ Relationship:_____ Phone #_____

Who referred you to this office?_____

Method of payment: (circle one)____cash____check_____credit card *(MC, Visa, AMEX)*_____

Who is responsible for payment (if not you)?_____

* *

Are you taking a blood thinner? N Y – name:_____

(PLEASE NOTE: we cannot do bodywork on you if you are taking prescription blood thinners – aspirin is not a problem? Blood thinner medication is not an issue for breathwork)

Describe major complaint:_____

_____

When and how did your condition develop?_____

_____

What makes your condition worse?_____

_____

List diagnosis (if known) and current treatment:_____

_____*(If available, please bring current reports: MRI, X-rays, Medical)*

Are you currently under doctor care? N Y – please explain:_____

_____

If auto accident, give date and description:_____

_____

Results from previous massage treatments:_____

_____

All surgeries & serious illnesses with approximate year:_____

_____

Dental work: Dentures? N Y – full___, partial___; Implants: N Y; Bridge: N Y – permanent____, removable____

Do you wear contact lenses? N Y

List **ALL** current medications and their purpose:_____

_____

(over please)

Do you have any skin disorders or allergies? N Y – please explain:_____

_____

Do you regularly drink caffeine beverages (coffee, tea, sodas, etc.) N Y – frequency_____

Do you smoke? N Y – how much?_____

Are you pregnant? N Y – estimated due date?_____

Are you participating in a regular fitness program? N Y – please describe:_____

_____

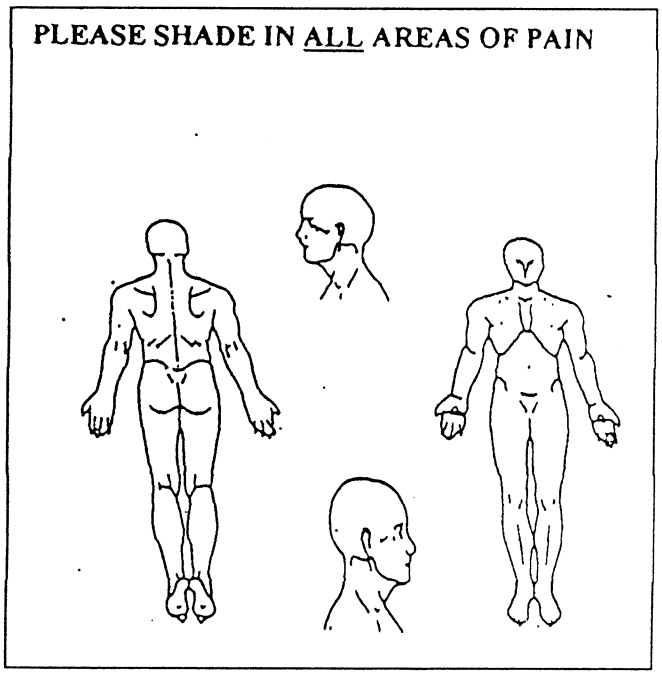
Do you have any other medical condition or physical limitation that I need to know before you receive this bodywork?

N Y – please explain:_____

Please circle any of the following that apply, present or past:

AIDS (or HIV related
Abdominal hernia
Hiatal Hernia
Acid Reflux
Stomach Disorders
Constipation
Diarrhea
Arthritis
Bursitis
Diabetes
Cancer
Shortness of Breath
Chest Pain
Heart Conditions
Low Blood Pressure
High Blood Pressure
Varicose Veins
Blood Clots
Dizziness
Loss of balance
Fainting Spells
Ears Ring
Edema

Severe Irritability
Severe Depression
Severe Menstrual Pain
PMS
Fatigue
Broken Bones
Herniated Disc
Headaches
Sinusitis
TMJ
Neck Pain
Back Pain
Sciatic Pain
Knee Pain
Feet Cold
Foot Numbness
Foot Pain
Shoulder Pain
Arm / Elbow Pain
Carpal Tunnel
Hand Numbness
Hands Cold
Scoliosis



I have listed ALL my known medical conditions, physical limitations, and medications. **I will inform my therapist of any changes in my physical health or medications.** I understand that a licensed massage therapist does not diagnose illness, disease, or any other medical, physical or psychological disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any problems that I have.

I agree to pay for all services at the time they are rendered, unless prior arrangements have been made.

CANCELLATIONS and MISSED APPOINTMENTS: Unless you are ill or have an emergency, we require 24 hr. *notice by phone (Monday – Friday) for any schedule changes, or you may be responsible for the full session fee.* We cannot do bodywork sessions if you are sick. If there is a question, please call.

I understand the information contained herein is privileged and confidential. I authorize the release of any information pertaining to my health to my attorney, insurance company, or referring physician / therapist.

INSURANCE COVERAGE: Our prescription form completed by your physician must be on file prior to treatment. I will give you the forms to file to your insurance company after payment has been made.

Signature:_____ Date:_____

If client is a minor, signature of parent/guardian:_____

I.T.S.

CRANIAL / STRUCTURAL DECOMPRESSION

CLIENT TREATMENT/ACCEPTANCE INFORMATION

NAME:

Residential Address:

Mailing Address:

Day Phone:

Evening Phone:

Primary Physician:

Emergency Contact:

Emer-Cntc Phone:

Physician Phone:

CONTRAINDICATIONS : Indicate any that apply

	YES	NO	UNKNOWN
> 13 Yrs of Age			
Blood Thinners			
Pregnancy			
Acute Conditions; such as trauma			
Acute Intracranial Hemorrhage			
Recent Skull Fracture			
Intracranial Aneurysm			
Active Encephalitis or Meningitis			
Brain Tumors			
Brain Shunts or Stints			
Brain Protrusion @ foramen magnum			
Detached Retina: needs (4) months and Dr. Release			
Metal Plates across sutures of head			
Recent Not fully healed major surgeries			

CAUTIONS: Indicate any that apply

	YES	NO	UNKNOWN
Metal Facial Plates			
Facial Surgeries			
Cranial Metal Plates & Screws			
Cranial Surgeries			
Severe or Prolonged Headaches: (3) wks			
Recent Healed Major Surgeries			

CAUTION MITIGATION: Cite & Describe

I verify that all above information is true and accurate. Int:_____

I verify that all above Caution Mitigation information has been explained to me by my therapist and is understood by me. Int:_____

I fully authorize my therapist to perform the following treatment.

Client Signature:

Date: