CLIENT HISTORY FORM

Name: _____ Date: _____

Address: _____ Email: _____

City: _____ _____State:_____ Zip: _____

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

Height: _____ Weight: _____ Date of Birth: _____

Occupation: _____

Emergency contact: _____ Relationship: _____ Phone # _____

Who referred you to this office? _____

Method of payment: (check one) Cash __ Check __ Credit Card: __MC, __Visa, __Amex

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

Are you taking a blood thinner? Y__ N__ 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 breath work*)

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: MRJ, X-rays, Medical)*

Are you currently under doctor care? Y___ N___ (If Yes, Explain)_____

If auto accident, give date and description: _____

Results from previous massage treatments: _____

All surgeries & serious illnesses with approximate year: _____

Dental work: Y___ N___ (If Yes, Explain**) _____**

Do you wear contact lenses? Y___ N___ Do you wear orthotics? Y___ N___

List ALL current medications and their purpose: _____

Do you have any skin disorders or allergies (i.e. latex)? Y___ N___ (If Yes, Explain) _____

Do you regularly drink caffeine beverages (coffee, tea, sodas, etc?) Y___ N___ - frequency_____

Do you smoke? Y___ N___ (If Yes, How Much) _____

Are you pregnant? Y___ N___ (If Yes, Estimated Due Date) _____

Are you participating in a regular fitness program? Y___ N___ (If Yes, Please Describe)

_____

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

Y___ N___ (If Yes, Explain) _____

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

__ AIDS (or HIV related	__ Abdominal hernia	__ Hiatal Hernia	__ Acid Reflux	__ Constipation
__ Stomach Disorders	__ Diarrhea	__ Arthritis	__ Bursitis	__ Diabetes
__ Shortness of Breath	__ Cancer	__ Chest Pain	__ Heart Conditions	__ Edema
__ Low Blood Pressure	__ Varicose Veins	__ Blood Clots	__ Dizziness	__ Sciatic Pain
__ High Blood Pressure	__ Fainting Spells	__ Ears Ring	__ Severe Irritability	__ Fatigue
__ Severe Depression	__ PMS	__Broken Bones	__ Herniated Disc	__ Headaches
__ Severe Menstrual Pain	__ Sinusitis	__ TMJ	__ Neck Pain	__ Back Pain
__ Loss of balance	__ Knee Pain	__ Feet Cold	__ Foot Numbness	__ Foot Pain
__ Ann / Elbow Pain	__ Shoulder 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 hour notice 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:_____

CLIENT HISTORY FORM

PLEASE PRINT THIS PAGE AND BRING WITH YOU

PLEASE SHADE IN ALL AREAS OF PAIN