# 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)?_______________________________________________

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**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 <u>not</u> an issue for breathwork)***

Describe major complaint:_______________________________________________________________

_______________________________________________________________________________________

<u>When</u> and <u>how</u> 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: <u>Dentures?</u> N Y – full___, partial___; <u>Implants:</u> N Y; <u>Bridge:</u> N Y – permanent____, removable____

Do you wear contact lenses? N Y Do you wear orthotics? N Y Facial surgeries? N Y __________________

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

_______________________________________________________________________________________

***(over please)***

Do you have any skin disorders or allergies (i.e. latex)? 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:____________________

________________________________________

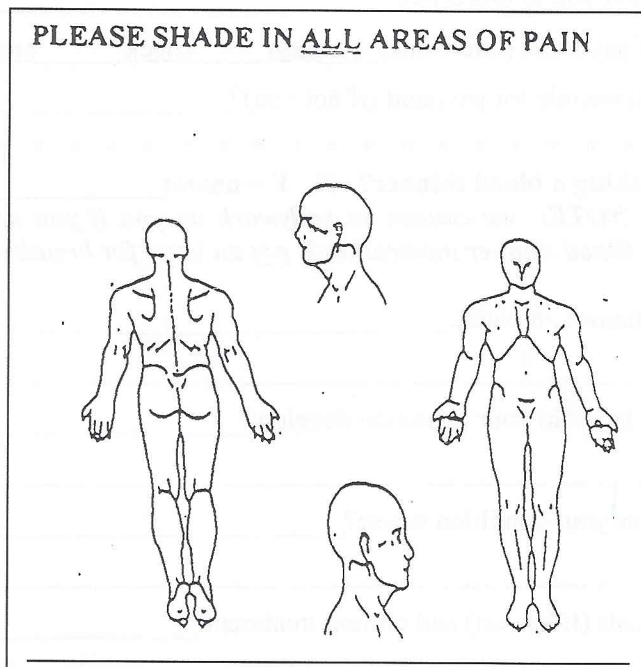
Do you have any other medical condition or physical limitation that I need to know before you receive this bodywork?

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 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:______________________________