



# Client Health History

Thank you for taking a few minutes to tell me about yourself. This will help me focus on what will be most beneficial while working together.

Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 2009  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_ -- \_\_\_\_ Email Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

\* \* \* \*

Have you ever had a professional massage/CranioSacral/Reflexology treatment?  Yes or  No Was the experience enjoyable?  Yes or  No Comments: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ -- \_\_\_\_

In case of **Emergency** call: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ -- \_\_\_\_

## MEDICAL HISTORY

Please indicate the conditions you have

Now ( **N** ) or had in the Past ( **P** )

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Disc Problems	<input type="checkbox"/> <b>Infections/Infectious Disease</b>
<input type="checkbox"/> <b>Allergies/Sinus Problems</b>	<input type="checkbox"/> <b>Diabetes</b>	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Joint Inflammation/Pain
<input type="checkbox"/> Artificial Joints/Pins	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> <b>Pregnant? What Month?</b>
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Fractures	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Back Conditions/Pain	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bruising	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Skin Conditions
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Smoke/Recreational Drugs
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> <b>High/Low Blood Pressure</b>	<input type="checkbox"/> <b>Varicose Veins</b>
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> <b>Other</b> _____

Are you under the care of any other health care provider?  Yes or  No

If so who, and please explain the condition: \_\_\_\_\_  
\_\_\_\_\_

Are you on any prescribed or over the counter **medications**?  **Yes** or  **No** Please list:

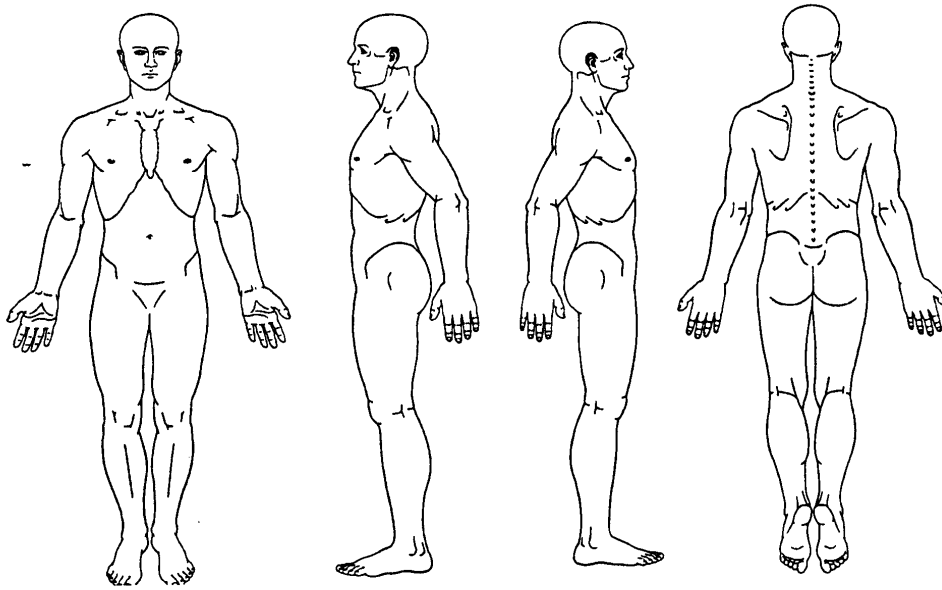
\_\_\_\_\_  
\_\_\_\_\_

Have you recently (past 3 years) had **surgery**?  Yes or  No Please Explain: \_\_\_\_\_

Have you suffered an **acute (recent) injury**?  Yes or  No Please Explain: \_\_\_\_\_

Do you wear contacts  Yes or  No

Are you allergic to Nuts?  Yes or  No



**Please identify any areas of Stress, Tension, or Pain**

Primary complaint (if any):                      Pain Level: Low Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

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**Head**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Intracranial hemorrhaging | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Brain Tumor           | <input type="checkbox"/> Jaw / Dental Pain         | <input type="checkbox"/> Recent head/Skull injury |
| <input type="checkbox"/> Herniation of Medulla | <input type="checkbox"/> Pregnant                  | <input type="checkbox"/> Stroke                   |

**Feet**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Athletes Feet | <input type="checkbox"/> Hammer Toe       | <input type="checkbox"/> Scar of past injury   |
| <input type="checkbox"/> Bruises       | <input type="checkbox"/> Ingrown toe nail | <input type="checkbox"/> Ticklishness          |
| <input type="checkbox"/> Bunions       | <input type="checkbox"/> Pain             | <input type="checkbox"/> Tissue Texture change |
| <input type="checkbox"/> Calluses      | <input type="checkbox"/> Puffiness        | <input type="checkbox"/> Warts                 |
| <input type="checkbox"/> Corns         | <input type="checkbox"/> Pregnant         | <input type="checkbox"/> Plantar Fasciitis     |
|  |   | <input type="checkbox"/> Other _____           |

How would you define your dietary habits?     Excellent     Good     Fair     Poor

Indicate with an "X" your present levels of:

**Energy**      Low.....High

**Health**      Low.....High

**Stress**      Low.....High

# BodyWork Policies

## Medical Conditions

If you have a specific medical condition, massage/body work may be contraindicated (should not be received). A referral from your primary care provider may be required prior to services being provided. Because massage/body work is contraindicated, I agree to keep the practitioner updated as to any new conditions or changes in my medical profile, and understand that there shall be no liability on the practitioners part should I forget to do so.

I acknowledge that the therapist does not diagnose, treat, or cure medical conditions.

## Confidentially

All discussions/information with-in the session will remain in strict confidentiality on the part of the practitioner.

## Cancellation Policy

A twenty-four (24) hour cancellation notice is appreciated with the exception of emergencies.

## Communication with Therapist

I understand that the purpose of bodywork is for relaxation and relief. If I experience any pain or discomfort I will ask the pressure/touch of the strokes be adjusted to my level of comfort.

## Payment Policies

Payment is to be made with cash or check. Any returned checks will be subject to a \$25 charge.

## Right of Refusal

Both the practitioner and the client have the right to refuse or terminate treatment at any time.

## Sexual Advances

It is understood that if any illicit or sexually suggestive remarks are advanced or made by me, it will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Signed \_\_\_\_\_ Date \_\_\_\_\_