Client History Form

Name:_____ Date:_____

Address:_____

Email:_____ Cell Phone:_____

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

Emergency Contact:_____ Relationship:_____ Phone:_____

Who referred you to this office?:_____

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Are you taking a blood thinner? (prescription/over the counter) **Y / N** name:_____

Have you had a concussion/TBI in the last 6 months? **Y / N**

Do you have a heart condition or pacemaker? **Y / N**

Describe major complaint:_____

Please describe the goals you want to achieve during the course of treatment:_____

_____

When and how did your symptoms develop?_____

_____

What makes your symptoms worse?_____

What makes your symptoms better?_____

List diagnosis, if known, and current treatment:_____

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

If you have experienced any auto accidents, falls, other traumas (physical and/or emotional) please list approximate date and description:_____

_____

All surgeries and serious illness with approximate year:_____

_____

Dental work: Dentures **Y / N** full / partial; Implants **Y / N**; Bridge **Y / N** permanent / removable

Do you wear contact lenses? **Y / N** Do you wear orthotics? **Y / N**

Have you had facial surgeries: **Y / N** please explain if yes:_____

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

_____

Do you have any skin disorders or allergies? **Y / N** please explain if yes:_____

Do you regularly drink caffeinated beverages? **Y / N** frequency?_____

Do you smoke? **Y / N**

Are you pregnant or trying to get pregnant? **Y / N**

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

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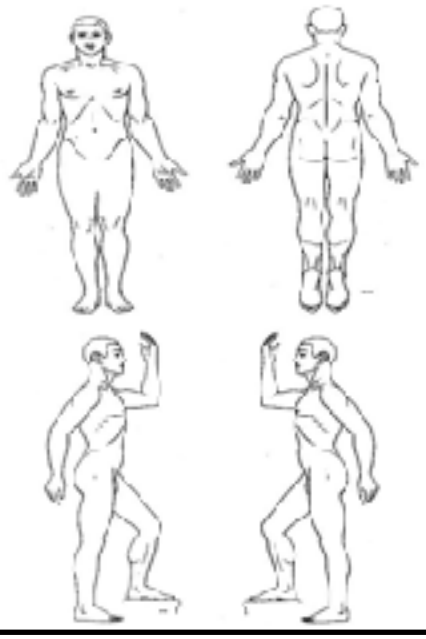
Do you have any other physical condition or limitation that would be important for me to know before we proceed with this work? **Y / N** please describe:_____

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

Abdominal hernia	Severe Irritability
Hiatal hernia	Severe Depression
Acid Reflux	Severe Menstrual Pain
Stomach Disorders	PMS
Constipation	Fatigue
Diarrhea	Broken Bones
Arthritis	Herniated Disc
Bursitis	Sinusitis
Diabetes	TMJ
Cancer	Neck Pain
Shortness of Breath	Mid Back Pain
Chest pain	Low Back Pain
Heart Conditions	Sciatic Pain
Low Blood Pressure	Knee Pain
High Blood Pressure	Feet Cold/Numb
Varicose Veins	Foot Pain
Blood Clots	Shoulder Pain
Dizziness	Arm/Elbow Pain
Loss of Balance	Carpal Tunnel
Fainting Spells	Hands Cold/Numb
Ears Ring	Scoliosis
Edema	Concussion

Please mark ***all*** areas of pain



I grant permission to use the application of weighted tuning forks and crystals directly to my body; as well as unweighted/weighted tuning forks and crystals in my Biofield. I am aware that I may verbally revoke this permission at any time before, during, or after a session.

I have listed ALL my known medical conditions, physical limitations, and medications, and **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 spinal manipulations. I am responsible for consulting a qualified physician for any problems I may have.

I agree to pay for all services at the time they are rendered.

Cancellations/Missed appointments: **24 hour notice for any schedule change is required. Unless you are ill or have an emergency, you will be responsible for the full session fee.**

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.

Signature:_____ Date:_____
(Parent/Guardian if client is under 18)