

PERSONAL HEALTH INFORMATION

Title	First Name	MI	Last Name	Date
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Address			Occupation	
<input style="width: 100%;" type="text"/>			<input style="width: 100%;" type="text"/>	
City	St	Zip		
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>		
Email			Home Phone/Notes	
<input style="width: 100%;" type="text"/>			<input style="width: 100%;" type="text"/>	
Referred by person			Cell Phone/Notes	
<input style="width: 100%;" type="text"/>			<input style="width: 100%;" type="text"/>	
Referred by other			Work Phone/Notes	
<input style="width: 100%;" type="text"/>			<input style="width: 100%;" type="text"/>	
DOB			Emergency Contact	
<input style="width: 100%;" type="text"/>			<input style="width: 100%;" type="text"/>	
Primary Health Care Physician			Relationship	
<input style="width: 100%;" type="text"/>			<input style="width: 100%;" type="text"/>	
Primary Physician Phone/Notes			Emergency Contact Phone/Notes	
<input style="width: 100%;" type="text"/>			<input style="width: 100%;" type="text"/>	

Permission to consult with primary care physician? Please initial if yes. Yes Initial No

Other Physicians/Therapists/Complementary Health Care Providers/Phone/Notes:	Permission to consult?	Yes	Initial	No
<input style="width: 100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
<input style="width: 100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
<input style="width: 100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

Medical History:

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Decrease Range of Motion	<input type="checkbox"/> HIV	<input type="checkbox"/> Nervous Tension	<input type="checkbox"/> Surgery
<input type="checkbox"/> Accident	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Joint Ache	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Upper Back Pain
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Disk Problem	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Sprains	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Whiplash Seizures
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Stroke	

Other:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Caffeine/Nicotine	<input type="checkbox"/> <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Drugs/Alcohol	<input type="checkbox"/> Pregnant	<input type="checkbox"/> <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <input style="width: 100%;" type="text"/>

Other/Details:

History/Notes:

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Are you currently seeing a medical practitioner? Please explain if yes. Yes No _____

Are you currently seeing a psychotherapist or are you attending group support meetings? Please explain if yes. Yes No _____

Medications/Purpose/Dosage:

Supplements/Purpose/Dosage:

Exercise/Stress Reduction Activities:

<input type="checkbox"/> Aerobics	<input type="checkbox"/> Sports	<input type="checkbox"/> Swimming
<input type="checkbox"/> Running	<input type="checkbox"/> Biking	<input type="checkbox"/> _____
<input type="checkbox"/> Walking	<input type="checkbox"/> Gym	<input type="checkbox"/> _____

Details of Exercise/Stress Reduction Activities/Notes:

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Other Physical Activities/Details/Notes:

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Massage/Bodywork History/Treatment Information:

Have you ever received a professional massage? Yes No If yes, Frequency _____ Date of last massage _____

What type of massage/bodywork have you received? _____

What type of massage/bodywork do you prefer? _____

What results are you seeking from treatment? _____

Prioritize the areas of your body that need treatment. _____

Please check areas of your body that you give permission to receive massage. Head Face Neck Shoulders

Arms Hands Upper Chest Abdomen Back Hips Buttocks Legs Feet

Treatment Details/Notes:

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Client Agreement of Responsibility:

I have stated all medical/mental conditions, treatments and medications that I am aware of and I will update the massage therapist of any changes in my health status, treatments and medications. Initial

I understand that it is my choice to receive massage/neuromuscular/acupressure therapy. I understand that treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain and/or for increasing circulation or energy flow. I agree to immediately communicate to the massage therapist any time I feel that my well being is being compromised. Initial

I understand that massage therapists do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage/bodywork therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. Initial

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I also understand that I am responsible for payment if third party payment is not made. Initial

I agree to give 24 hours notice to cancel or reschedule my appointment. I understand that missed appointments or those cancelled with less than 24 hours notice are subject to a \$75 late cancellation fee. Initial

I understand that third parties cannot be billed for missed appointments and that payment is my responsibility.

I understand that it is my responsibility to be on time for my appointment and ready to receive therapy at the appointed time; that any time that I am late will be deducted from my session and that I am responsible to pay for the full session. Initial

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this record will be placed in my client chart and maintained for six years. Initial

Client Name (Please Print) _____ Date _____

Parent, Guardian or Client's legal representative _____

Signature _____