CLIENT INFORMATION & HEALTH HISTORY FORM

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Today's Date: ________________

Name: ________________________________ Date of Birth _____________

Phone: Day_____________________ Eve_____________________

Address: ____

City____________________________ State________ Zip______________

email: _____________________________

May we contact you via email to:

share health & wellness tips? Yes No
regarding updates in our services? Yes No

regarding communications pertaining to your sessions? Y our privacy is strictly protected. Yes No

Emergency Contact: _________________________________

Phone _____________________ Relationship: ______________________

Permission to consult with primary provider? ____Yes ____No

This is only indicated if you either have a potentially communicable condition, or a condition in which Massage/Bodywork might be contraindicated, or require specific instructions.

Primary Physician's Name:_______________________________________
Phone:____________________ Facility: ______________________________

• How did you hear about my services?

• What is your occupation and sports/hobbies? (How do you use your body in the day-to-day?)

• Have you been under a doctor's care in the previous year? If so, for what condition?

GENERAL OVERVIEW OF SIGNIFICANT HEALTH EVENTS:

Please list dates and nature of all **surgeries, injuries, broken bones, significant illnesses or periods of emotional challenge** below .

Date: EVENT:

____
____
____
____
____
____
____
____

• Please feel free to share any other considerations you would like to bring to my attention to ensure that your needs are best served. There is more space to write on the back as needed.

Have you ever experienced any of the following conditions?

Please put «P» if PAST condition, and a «C» for a CURRENT condition.

MUSCULO-SKELETAL:

___ bone or joint disease ______________________

___ tendonitis _______________________________

___ bursitis__________________________________

___ broken/fractured bones____________________

___ arthritis__________________________________

___ sprains/strains____________________________

___ low back, hip, leg pain_____________________

___ disc problems____________________________

___ neck, shoulder, arm pain___________________

___ numbing/tingling_________________________

___ whiplash_________________________________

___ spasms/cramps____________________________

___ restricted range of motion___________________

___ jaw pain/TMJ______________________________

___ lupus_____________________________________

___ other_____________________________________

CIRCULATORY:

___ heart condition____________________________

___ varicose veins______________________________

___ blood clots/stroke__________________________

___ high blood pressure________________________

___ low blood pressure_________________________

___ lynphedema_____________________________

___ breathing difficulty________________________

___ sinus problems___________________________

___ asthma__________________________________

___ allergies_________________________________

___ phlebitis_________________________________

___ hemophilia ______________________________

SKIN:

___ allergies
___ rashes
___ eczema/psoriasis__________________

___ athlete's foot_____________________

___ warts ____________________________

___ other:____________________________

DIGESTIVE:

___ constipation ______________________

___ gas/bloating _______________________

___ diverticulitis ______________________

___ irritable bowel syndrome ___________

___ hemorrhoids ______________________

other:____________________________

NER VOUS SYSTEM:

___ herpes/shingles____________________

___ chronic pain ______________________

___ fatigue___________________________

___ sleep disorders____________________

___ headaches/migraines______________

___excess stress______________________

___ epilepsy/seizures _________________

___ other_____________________________

___ Cesarian section delivery___________

___ PMS/menopause _________________

___ other_____________________________

OTHER:

___ cancer/tumors_____________________

___ diabetes_________________________________

___ eating disorders___________________________

___ prostate__________________________________

___ depression_______________________________

___ drug/alcohol addiction_____________________

___ nicotine/caffeine addiction_________________

___ thyroid __________________________

INFECTIOUS DISEASES:

___ HIV/AIDS ______________________

___other:____
____

LIFESTYLE HABITS:

What does your diet consist of? (Yes, No, Comments)

Omnivore (anything/everything): _______________________

Vegetarian: ____________ Vegan: ______________

Food allergies? ____

Food cravings? __________________ Sweets? ________ Salty: ________
Fried? ________ Processed/Fast foods: _________ Other: _____________

Organic when possible? ___________ Local foods: ________________

What are your eating/meal patterns?

Meals: __________________ # Snacks: ________________________

Do you eat at consistent times each day?

Do you eat after within 3 hours before bed?

How much water do you drink?

Do you eliminate with regularity (bowel movements, urination)?

____

Do you sleep well? Enough? What are your sleep patterns?

____

____

Your experience is held in the highest confidence and respect .

Your privacy, safety, and comfort are my absolute priorities.
I am privileged to be entrusted as a contributor in support of your well-being. Thank you very much!

CONSENT TO RECEIVE SERVICES:

Please read the following and sign your consent:

"I have completed this form to the best of my knowledge. I understand that the services offered by this practitioner are designed to be a health and personal growth aid and are in no way to take the place of a physician's care when it is indicated. Information exchanged during any healing session is educational in nature and is intended to help me become more familiar with my own health status and is to be used at my own discretion. I understand that when attending workshop events offered by this practitioner, some activities include the use of therapeutic touch, breath practices, movement, and self-inquiry. I in no way hold this practitioner or her associates responsible for any damages or injury that may result from participating in these events, and acknowledge that I am personally responsible for determining what extent participation in such activities is comfortable for me. I understand that this practitioner reserves the right to terminate a session at her own discretion, in the event of a client's inappropriate behavior, and that these services are strictly therapeutic and non-sexual in nature." **Initials: __________**

Please be sure to drink plenty of water following a bodywork session to assist in healthful elimination and rehydration. W e are multidimensional Beings, and our entire life experience is imprinted in our tissues. Thus, bodywork can be a deeply affecting experience, not only physically , but psychologically , emotionally and spiritually as well. I encourage you to afford yourself the important gift of personal time and space to honor and integrate your physical, energetic and emotional responses and refreshed self-awareness before moving back into the demands of your day . This shall help to maximize the benefits of your sessions. Y ou may also find it supportive to maintain a journal, recount your dreams, consciously set intentions, and cultivate forgiveness, compassion, and loving-kindness towards yourself and others. These practices, as well as many others, can all be powerful vehicles towards healing and personal evolution.

Initials: _________

CANCELLATION POLICY : Your time is reserved especially for you. Missed appointments and cancellations made within 24 hours of your appointment will be charged a fee of $50.00, except in the event of an emergency. Thank you for respecting our time! Initials: ________

Your gracious referrals are what sustain my Life Purpose in offering this work to the world. Thank you so much for the opportunity to serve!

May you Thrive and know Wellness and Peace!

Client's signature ________________________________ Date ________________

Cancer History & Treatment - Please only complete the following pages if you have a history of care for cancer. Thank you!

Have you been diagnosed with cancer? If so, when, and what type(s)?
Are you currently in treatment?

Surgery Chemotherapy Radiation

___

Past : ___

Current : ___

Have you had lymph nodes removed? If so, from where, and when?

Have you been given information about lymphedema and how to help minimize your risks?

Do you have a port or device for Rx delivery?

Have you received massage or other touch therapies before today's session?

Have those been positive experiences for you?

Do you have any concerns, requests or considerations regarding today's session?

Are you currently receiving other forms of “CAM”:

Complementary and Alternative Medicine and support?

____ acupuncture ____ movement arts (e.g., dance, stretching, tai chi, etc.) ____ nutritional guidance ____ touch therapies ____ energywork
____ meditation ____ aquatic therapies ____ art and music therapies
____ spiritual, emotional, psychological support groups
____ supportive family and/or friends?

____ are you still working? if not, for how long?

Other:

Current Treatment Symptoms:
Please CIRCLE any of the following you may be experiencing.

Nausea
Vomiting
Fatigue
Sleep Disturbances
Neuropathy
Skin changes; hands & feet,,,
Brain fog
Anxiety
Depression
Hair loss
Heightened sensitivities: to scents, sound, touch, temperature, other?
Fever

Dry mouth
Mouth sores
Constipation
Diarrhea
Changes in taste sensation
Changes in appetite
Significant weight loss or gain
Emotional state
What brings you joy, inner peace, calm, balance?

Session Plan: (the following are me, as the Practitioner, to complete)

MLD: contraindications or considerations

MLD: areas of focus

Eastern Organ systems to consider and why-- Reflexology focus:

Use of OILS: allergies, sensitivities, preferences choice of oils & why?
Sesame

Brahmi Coconut Mahanarayama Neem

Others: