

PERSONAL HEALTH INFORMATION

CONTACT INFORMATION:

Name: _____ Date: _____ Referred by: _____
Address: _____ City/State/Zip: _____
Birthday: _____ Occupation/Employer: _____
Phone – Home: _____ Phone – Cellular: _____
E-mail Address: _____ Phone: _____
Emergency contact: _____ Phone: _____

MASSAGE & TREATMENT HISTORY:

Have you ever received professional bodywork? _____ If yes – frequency: _____ Date of last massage: _____
What do you hope to receive from your sessions? _____

CONSENT FOR TREATMENT:

Please indicate consent for treatment of the body by initialing appropriate choice below:

_____ I give my consent for full body treatment (does not include breast tissue).
_____ I give my consent for full body treatment including breast tissue (requires additional paperwork).
_____ I give my consent for full body treatment EXCLUDING the following areas _____

ACTIVE TREATMENT :

Are you presently seeing a medical practitioner? _____ If yes, please explain. _____

Please initial if I may discuss your history/condition with your physician. _____

Healthcare Practitioner/Specialist: _____ Phone: _____

Are you presently seeing a psychotherapist or attending regular support group meetings? _____ If yes, please explain. _____

Please initial if I may discuss your history/condition with your physician. _____

Healthcare Practitioner/Specialist: _____ Phone: _____

PREVENTATIVE HEALTHCARE / HEALTHCARE MANAGEMENT:

Please list all stress reduction and exercise activities (include frequency). _____

Please list current medications (prescription or over the counter). _____

PRESENT & PREVIOUS ISSUES:

List all surgeries/medical procedures (include year). _____

List all accidents (include year). _____

PRESENT & PREVIOUS ISSUES CONTINUED: Please indicate if you have ever had any of the following:

Musculo-skeletal

- Bone/joint disease
- Tendonitis
- Bursitis
- Broken/fractured bones
- Arthritis
- Sprains/strains
- Low back, hip, leg pain
- Neck, shoulder, arm pain
- Headaches/head injuries
- Spasms/cramps
- Jaw pain/TMJ
- Lupus
- Other

Skin

- Allergies
- Rashes
- Warts
- Athlete's foot
- Other

Circulatory

- Heart condition
- Varicose veins
- Blood clots
- High/low blood pressure
- Lymph edema

Respiratory

- Breathing difficulty
- Sinus problems
- Allergies
- Other

Digestive

- Constipation
- Gas/bloating
- Diverticulitis
- Irritable bowel syndrome
- Other

Auto Immune Disorders

- Rheumatoid Arthritis
- HIV/AIDS

Nervous system

- Herpes/shingles
- Numbness/tingling
- Chronic pain
- Fatigue
- Sleep disorders
- Other

Reproductive

- Pregnant? Stage
- PMS
- Other

Infectious disease (s)

List/describe below

Other

- Cancer/tumors
- Diabetes
- Eating disorders
- Depression
- Drug/alcohol addiction
- Nicotine/caffeine addiction

Please note any pathology past or present not listed above: _____

I have chosen to receive bodywork therapy from Karina Rhode (i.e. "Practitioner"). I realize that treatment I receive is for the well being of my body and mind. This may include stress reduction, relief of muscular tension, spasm and pain, increased circulation or energy flow. I agree to communicate with my practitioner any time I feel that my well-being is being compromised. I understand that Practitioner will not diagnose illness, disease, physical or mental disorder. Practitioner will not prescribe medical treatment, pharmaceuticals, or perform deliberate skeletal/spinal adjustments. I acknowledge that bodywork 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. I acknowledge that Practitioner's treatment is a non-sexual service. Practitioner may terminate session as a result of sexual advances, behavior, or comments and I will still be responsible for full payment of the session.

I have stated all medical conditions that I am aware of and will update Practitioner of any changes in my health status. I acknowledge that my health history and personal information records are confidential. My therapist will not release these records to any party without my consent.

Client Signature: _____ Date: _____