



CONFIDENTIAL CLIENT HISTORY

DATE / /

CONTACT INFORMATION

NAME DATE OF BIRTH

ADDRESS

CITY/STATE/ZIP OCCUPATION

PHONE HOME CELL WORK

EMAIL

EMERGENCY CONTACT NAME PHONE

WHOM MAY I THANK FOR REFERRING YOU? PLEASE CIRCLE ONE AND SPECIFY BELOW. FRIEND | WEBSITE | INSURANCE | OTHER

CURRENT CONDITION

PLEASE DESCRIBE YOUR CURRENT CONDITION AND SYMPTOMS. MARK ON THE DIAGRAM TO THE RIGHT USING THE SYMBOLS PROVIDED.

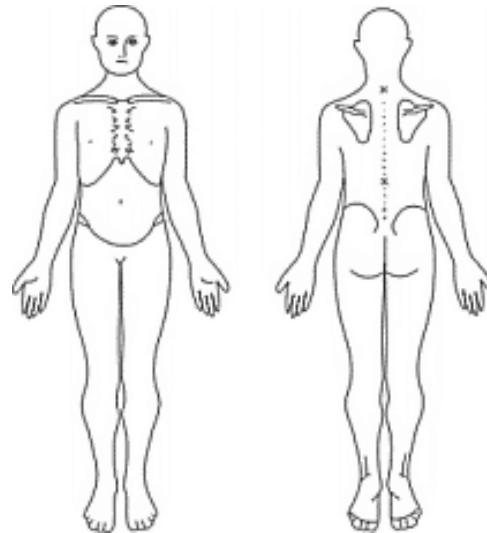
Horizontal lines for describing the current condition and symptoms.

HOW LONG HAVE YOU HAD THIS CONDITION? HOW DID IT START?

Horizontal lines for duration and onset of the condition.

WHAT AGGRAVATES IT? WHAT RELIEVES IT?

Horizontal lines for aggravating and relieving factors.



- ACHING OOO
SHOOTING >>>
STABBING XXX
BURNING ###
NUMBNESS OR TINGLING ///

PLEASE CIRCLE THE ANSWER THAT BEST DESCRIBES HOW YOU FEEL NOW. (1 = POOR 5 = EXCELLENT)

Table with 5 columns (1-5) and 5 rows (ENERGY LEVEL, STRESS LEVEL, QUALITY OF SLEEP, EATING HABITS, EXERCISE HABITS).

APPROX. HOURS OF SLEEP PER NIGHT

NO. TIMES EXERCISE PER WEEK

PLEASE LIST ANY ACTIVITIES, SPORTS, HOBBIES. (I.E. JOGGING, HOCKEY, CRAFTS, COMPUTERS, ETC.)

Horizontal lines for listing activities, sports, and hobbies.

ARE THERE ANY ACTIVITIES YOU NO LONGER PARTICIPATE IN DUE TO HEALTH REASONS THAT YOU WISH YOU COULD STILL DO?

Horizontal lines for listing discontinued activities.

MEDICAL HISTORY

PLEASE INDICATE YOUR THERAPY / TREATMENT EXPERIENCE. (P = PAST C = CURRENT)

_____ MASSAGE THERAPY	_____ PRACTITIONER/CENTER
_____ CHIROPRACTOR	_____ DOCTOR/CENTER
_____ PHYSICAL THERAPIST	_____ THERAPIST/CENTER
_____ ACUPUNCTURIST	_____ PRACTITIONER/CENTER
_____ OTHER	_____ PLEASE SPECIFY
_____ OTHER	_____ PLEASE SPECIFY

PLEASE INDICATE IF YOU BELIEVE ANY OF THE FOLLOWING APPLY TO YOU. CIRCLE IF NECESSARY. (P = PAST C = CURRENT)

_____ HEART ATTACK	_____ ASTHMA	_____ JOINT DISLOCATION
_____ HIGH/LOW BLOOD PRESSURE	_____ OTHER RESPIRATORY CONDITION	_____ BONE FRACTURE
_____ STROKE OR ANEURYSM	_____ HEADACHES/MIGRAINES	_____ ARTHRITIS
_____ PACE MAKER	_____ DIZZINESS/FAINTING	_____ OSTEOPOROSIS
_____ OTHER HEART CONDITION	_____ NAUSEA	_____ RODS/PINS/PLATES/SHUNTS
_____ VARICOSE VEINS	_____ SPINAL INJURY	_____ FIBROMYALGIA
_____ BRUISE EASILY	_____ HEAD INJURY	_____ IMPLANTS (PLEASE SPECIFY)
_____ OTHER CIRCULATORY CONDITION	_____ EPILEPSY/OTHER SEIZURES	_____
_____ DIABETES	_____ OTHER NEUROLOGICAL	_____ TRANSPLANT (PLEASE SPECIFY)
_____ KIDNEY DISEASE	_____ CONDITION	_____
_____ CANCER (PLEASE SPECIFY)	_____ IRRITABLE BOWEL/COLITIS	_____ CORRECTIVE LENSES/CONTACTS
_____	_____ OTHER DIGESTIVE CONDITION	_____

ARE YOU PREGANT? Y / N HOW MANY WEEKS? LIST ANY PREGANCY RELATED CONDITIONS BELOW

PLEASE LIST ANY OTHER CONDITIONS THAT I SHOULD BE AWARE OF.

DO YOU HAVE ANY KNOWN ALLERGIES THAT MAY AFFECT MASSAGE? (I.E. OILS/LOTIONS)

HAVE YOU EVER BEEN HOSPITALIZED, HAD ANY MAJOR ACCIDENTS, ILLNESSES, OR SURGERIES? PLEASE DESCRIBE.

PLEASE LIST ANY MEDICATIONS THAT YOU CURRENTLY TAKE.

POLICY AGREEMENT

PLEASE READ THE STATEMENTS BELOW AND INITIAL TO CONFIRM THAT YOU HAVE READ AND UNDERSTAND.

_____ 24 hour advance notice is required when canceling an appointment, except in cases of illness, emergency or inclement weather. Cancellations without 24 hour notice will result in a charge for your session, as that time has been set aside specifically for you.

_____ I authorize Well Within to collect my personal and medical information as documented above in order to contact me and give permission for the clinic to leave messages regarding my appointments at any of the contact numbers I have provided above. I also understand that my personal and medical information is confidential and will not be disclosed to third parties without my consent.

_____ Well Within maintains a professional environment and reserves the right to terminate a session in the event of a client's inappropriate behavior, intoxication or sexual advances. Therapeutic massage is strictly non-sexual. Misconduct of a sexual nature will result in immediate termination of the session. Payment for appointed service will be rendered in full and inappropriate behavior will be reported to the authorities. Termination of a session is completely at the discretion of the therapist without a requirement of explanation.

_____ I understand that my practitioner is not a licensed MEDICAL healthcare provider and that bodywork/massage is not a substitute for medical care, medical examination or diagnosis. I have stated all my known medical conditions and will inform my practitioner of any change in my health status.

I have read the above statements and understand the policies of Well Within.

SIGNATURE

DATE
