WELL WITHIN MASSAGE AND INTEGRATED HEALTH

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.

_____

_____

_____

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

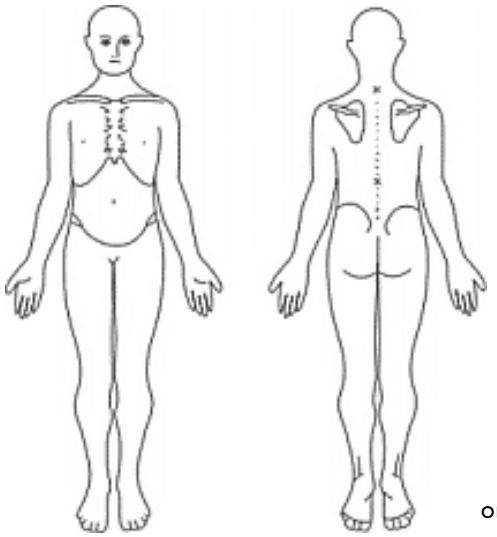
_____

_____

WHAT AGGRAVATES IT? WHAT RELIEVES IT?

_____

_____



ACHING OOO
SHOOTING > > >
STABBING X X X
BURNING # # #
NUMBNESS OR TINGLING ////

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

ENERGY LEVEL	○ 1	○ 2	○ 3	○ 4	○ 5	
STRESS LEVEL	○ 1	○ 2	○ 3	○ 4	○ 5	
QUALITY OF SLEEP	○ 1	○ 2	○ 3	○ 4	○ 5	
EATING HABITS	○ 1	○ 2	○ 3	○ 4	○ 5	
EXERCISE HABITS	○ 1	○ 2	○ 3	○ 4	○ 5	

APPROX. HOURS OF SLEEP PER NIGHT _____

NO. TIMES EXERCISE PER WEEK _____

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

_____

_____

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

_____

_____

MEDICAL HISTORY

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

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

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

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

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