CLIENT HISTORY FORM

Name:____Date:______________________________

Address:____Email:______________________________

City:____State:____________Zip:____________

Home Phone:______________________Work Phone:____________________Cell Phone:____________________

Height:_____Weight:______Age:_____ # of Children:______Occupation:_____________________________

Emergency contact:_________________________________Relationship:____________Phone #______________

Who referred you to this office?____

Method of payment: (circle one)____cash____check______credit card *(MC, Visa, AMEX)*________________

Who is responsible for payment (if not you)?____

* *

Are you taking a blood thinner? N Y – name:____

(PLEASE NOTE: we cannot do bodywork on you if you are taking prescription blood thinners – aspirin is not a problem! Blood thinner medication is not an issue for breathwork)

Describe major complaint:____

____

When and how did your condition develop?____

____

What makes your condition worse?____

____

List diagnosis (if known) and current treatment:____

_____________________________________*(If available, please bring current reports: MRI, X-rays, Medical)*

Are you currently under doctor care? N Y – please explain:____

____

If auto accident, give date and description:____

____

Results from previous massage treatments:____

____

All surgeries & serious illnesses with approximate year:____

____

Dental work: Dentures? N Y – full___, partial___; Implants: N Y; Bridge: N Y – permanent____, removable____

Do you wear contact lenses? N Y Do you wear orthotics? N Y Facial surgeries? N Y ____________________

List **ALL** current medications and their purpose:____

(over please)