personal data & health screen

Client Information

Name _____ Date of initial visit:

Address _____ _____

City/State _____ Referred by:

Date of Birth _____ _____

Phone _____ ☐ *cell* ☐ *home* ☐ *work*

Phone _____ ☐ *cell* ☐ *home* ☐ *work*

Email _____

Emergency contact: Name _____

Phone _____ Relationship _____

Medical Review

Please list any symptoms, conditions, or concerns you have using this list -->
Please list medications (include herbal supplements) and their purposes.

_____

_____

_____

Are you currently under the care of a medical professional for any of the conditions listed here? _____

Permission to communicate with your physician should the need arise? (fill in)

Name of Physician _____

City _____ Phone _____

Treatment for _____

This information is treated confidentially.
I ask that you read and sign this agreement between us:

Liz Brinson agrees to be fully present during sessions, to answer my questions about the work, and to offer a safe and supportive environment to facilitate my healing process. I (the client) agree to pay in full if I cancel within 24 hours of a previously scheduled appointment.

I understand that massage and bodywork do not replace medical treatment. Healing is a process and not an event, and I agree to take responsibility for my own healing by communicating clearly with my therapist about conditions of body or mind that may affect my work.

I am willing and ready to explore the possibilities of entering the healing process in a safe and supportive environment, in a practical and friendly way.

Signature _____ Date _____

- ☐ Recent skull / spinal Fx
- ☐ Other fracture/trauma
- ☐ Cerebral aneurysm
- ☐ Cerebral hemmorhage
- ☐ Down's Syndrome
- ☐ Herniated brain stem (Arnold-Chiari Syndrome)
- ☐ Rheumatoid Arthrities
- ☐ Shunt
- ☐ Spinal tap or epidural

- ☐ Arteriosclerosis
- ☐ Bruise easily
- ☐ Cancer/malignancy
- ☐ Chronic fatigue syndrome
- ☐ Fibromyalgia
- ☐ Fluid retention
- ☐ Fracture/Injury
- ☐ Headaches
- ☐ Herniated disc _____
- ☐ Hypertension
- ☐ Implants (dental, IUD, etc)
- ☐ Infectious disease (ie, HIV)
- ☐ Inner ear problem
- ☐ Menstruation troublesome
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Pain/stiffness
- ☐ Pregnancy
- ☐ Seizure disorder
- ☐ Skin - open sore or cut
- ☐ Skin - rash
- ☐ Surgery
- ☐ Thrombosis/Phlebitis/ Varicose veins
- ☐ Other _____

_____

Lifestyle Information

Please rate your…	HEALTHY.....TROUBLESOME	Do you use…	NEVER.....DAILY
LIFESTYLE	■-----■-----■-----■-----■	TOBACCO	■-----■-----■-----■-----■
NUTRITION	■-----■-----■-----■-----■	ALCOHOL	■-----■-----■-----■-----■
SLEEP	■-----■-----■-----■-----■	DRUGS	■-----■-----■-----■-----■
DIGESTION	■-----■-----■-----■-----■	CAFFEINE	■-----■-----■-----■-----■

How do you use your body? *How much/how often?*

WORK: _____

_____

PLAY (free time): _____

_____

EXERCISE: _____

_____

Are there specific aspects of your life that are particularly stressful? (For example, job, posture, habits, diet, family, etc.) _____

_____

Session

Previous experience with professional massage/bodywork _____

_____

_____

Do you wear contacts? yes / no …dentures? yes / no …hearing aid? yes / no

Areas of the body with particular sensitivity _____

Do you have any difficulty lying on back or front, or turning over? _____

_____

_____

Reasons for seeking out massage therapy now _____

_____

_____

_____

_____