Personal Medical History

Name: ____ Date: _____/_____/_____

Please describe the condition you are seeking treatment for and give a brief history, including onset:

____
____
____
____
____
____
____
____
____
____

What are your goals for treatment?

____
____
____

What other treatments have you tried for your pain?

____
____
____

My regular exercise is:

____
____

My goals for exercise are:

____
____

Name: ____________________________________ Date: _____/_____/_____

Are you aware of having or have you been diagnosed as having any of the following conditions or symptoms? If so, please indicate "C" for current or "P" for past where appropriate.

Asthma	______	Overweight	______	Memory Loss	______
Allergies	______	Underweight	______	Short Legs	______
Chronic Cough	______	Phlebitis	______	Scoliosis	______
Sinusitis	______	Hypertension	______	Arthritis	______
Migraines	______	Hypotension	______	Osteoporosis	______
Fibromyalgia	______	Depression	______	Polio	______
TMJD	______	Alcoholism	______	Cancer	______
Herpes	______	Drug Abuse	______	Seizures	______
Dental Problems	______	Clench/Grind	______	Stroke	______
Chronically Cold	______	Sleep Disorder	______	Cardiac Arrhythmia	______
Chronic Fatigue	______	Sleep Apnea	______	Angina	______
Diabetes	______	Auto Immune	______	Thyroid Disorder	______
Dizziness	______	Fainting	______	Vision Changes	______
Strength Changes	______	Tinnitus	______	Glasses	______
Abdominal Pain	______	Bloating	______	Pelvic Pain	______
Chronic Prostatitis	______	Painful Urination	______	Painful Defecation	______
Chronic Diarrhea	______	Incontinence	______	Constipation	______

Woman:

Pregnancies	______	Menstrual Pain	______	Urinary Frequency	______
Urinary Urgency	______	Stress Incontinence	______	Pelvic Pain	______
Menopause	______	Hormone Replacement	______		

Please list ***all*** other medical conditions that you have:

Name: ________________________________ Date: _____/_____/_____

I smoke _____ cigarettes, cigars, pipes per day.
I drink _____ cups of coffee/tea/caffeinated beverage per day.
I drink _____ alcoholic beverages per day.
I drink _____ glasses of fluid per day.
I chew _____ sticks of gum per day.

I sleep ______ hours per night.
I go to sleep at __________ and wake up at __________.
My sleep quality is _____ great _____ good _____ poor.
I have trouble _____ falling asleep _____ staying asleep _____ waking up.
When I wake up I feel _____ well rested _____ still tired.
I sleep on my _____ back _____ stomach _____ side.
I get up to go to the bathroom _____ times per night.
I have _____ sleep apnea _____ insomnia _____ uncomfortable bed.

What is your: Height ____________ Weight ___________
Are you: _____ Right Handed _____ Left Handed

Are you currently working? _____ No _____ Full-Time _____ Part-Time
Did you work before your symptoms began? _____ Yes _____ No
Did your pain cause you to stop working? _____ Yes _____ No

I watch _____ hours of TV per day.
I spend _____ hours playing video games, computer games or surfing the web.
I commute _____ minutes/hours to and from work each day.

My hobbies are:

____

____

My pain is worse when _____ sitting _____ standing _____ walking _____ sleeping.

List any additional activities that worsen your pain:

____

____

List anything that makes your pain better:

____

____

Name: ____ Date: _____/_____/_____

List all diagnostic tests you have had (and results) for your current pain/condition:

____

____

____

List all surgeries and approximate dates:

____

____

____

List all past injuries and approximate dates:

____

____

____

List all ***prescribed*** medications that you take currently, or have recently taken:

Medication:	Effects:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

List any ***over the counter*** medications, vitamins, minerals and dietary supplements that you currently take or have recently taken:

Medication/Supplement:	Effects:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

How much water do you drink per day:
____?
Do you have TMJ? _____ Yes _____ No
Do you have jaw pain associated with chewing or yawning? _____ Yes _____ No
Do you clench or grind your teeth? _____ Yes _____ No
When was your last dental appointment? ____
When was your last eye exam? ____
Do you wear bifocals/trifocals? ______ Yes _____ No
Do you wear a night guard or mouth splint? _____ Yes _____ No

Client Signature: ____

Client History Form

NAME: ____ Date: _____/_____/_____

How did you hear about us? ____

Address: _______________________________________

City, State, Zip: _______________________________________

____

____

Phone (Home): _______________________________________

Phone (Cell): _______________________________________

Phone (Work): _______________________________________

Email: _______________________________________

____

Date of Birth: _______________________________________

Occupation:

____

Have you had a professional massage before? _____Yes _____No

Primary reason for appointment/areas of pain or tension:

____

____

____

____

For Internal Use Only:

Added to QB: ________________________ **Added to Mailchimp:** ________________________

Added to iContact: ___________________ **Permission to Observe:** _____________________

Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. It is our desire to be effective and fair to all clients, and to provide quality care and individual attention. As our clinic continues to grow and expand is has become necessary to implement the following cancellation policy.

24 hour advance notice is required when cancelling or rescheduling an appointment. This allows the opportunity for someone else to take your time slot. If you fail to give us 24 hours advance notice you will be charged the full amount of your appointment fee **after the first occurrence**. This amount must be paid prior to or at your next scheduled appointment. Obviously life happens and emergencies come up. Please let us know your situation and we will handle on a case by case basis.

No-Shows:

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged the full amount for the "missed" appointment.

Late Arrivals:

Please plan on arriving 5-10 minutes prior to your scheduled appointment. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending on how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the full session.**

Thank you for your cooperation. We look forward to seeing you at your next appointment.

Sincerely,

Amber Davies CMTPT, LMT