PARTNERS IN HEALING
CLIENT INFORMATION FORM

Name: _____ Cell: _____

Billing Address: _____ Apt/Suite: _____

City/State/Zip: _____ Email: _____

Birthdate: _____ Age: _____ Gender: _____ Referred By: _____

Occupation: _____ General Health: Excellent___Good___Fair___Poor___

Stress Level: High___Med___Low___ Energy Level: High___Med___Low___

Exercise: What kind(s)? How often _____

Have you had Body or Healing Work previously? ____ Most recent? _____ What kind(s)?

_____

Pressure preference: Deep ___ Moderate ___ Light ___ Any areas to avoid? _____

Primary reason for appointment: _____

How long has this been present? _____ What brought it on? _____

Did you see a Dr.? Name: _____ Contact #: _____

Diagnosis: _____ Have you received any treatment? ___

If so, what types, when, how often?_____

Circle ALL that apply:
1) Therapy: Helped Made Worse No change What aggravates it? _____

2) This issue is interfering with: Work Sleep Exercise Is condition getting worse? ___

3) What words best describe your Experience? Painful Sharp Dull Burning

Aching Nagging Constant Intermittent Throbbing Shooting Stabbing Numb

Tingling Weak Restricted Fatigued Chronic Other _____

Goals for Therapy? _____

_____

Please make or attach a list of medications, herbs, vitamins & supplements you take:

Use back of page if needed _____

_____

Please Check and Circle ALL that apply, Past and Present.
If past or controlled with Medicine, please note this in the space provided.

___ Allergies/Sinusitis/Glaucoma

___ Asthma/CF/Breathing Issues

___ Chest Pain/Heart Condition

___ Anemia/On Anticoagulant

___ High/Low Blood Pressure

___ Varicose Veins/DVT's

___ Skin Rashes

___ Athletes Foot/Warts

___ Recent Cuts/Bruises/Sores

___ Cancers/Tumors

___ Diabetes/Hypoglycemia

___ Immune System/Sensitivities/Auto

___ Lyme/Valley Fever/Mononucleosis

___ HIV/Herpes/Hepatitis/Shingles

___ Covid19/Tuberculosis/Meningitis

___ Acid Reflux/Indigestion

___ Nervous Stomach/Nausea

___ Food Sensitivities - to what?

___ Constipation/Bloating/Diarrhea

___ IBS/Krohn's/Colitis

___ Sleep Disturbances/Insomnia

___ Fatigue/Low Energy

___ Depression/Anxiety/Other

___ Loss Experience(s)/Trauma(s)/PTSD

___ Loss of Balance/Dizziness

___ Loss of Consciousnesses/Seizures

___ Loss of Hearing/Tinnitus

___ Pregnant/Pregnancies Qty___Issues?

___ PMS/Endometriosis/Menopause

___ Prostate/ED

___ Arthritis/Bursitis - Area(s)?

___ Sprains/Strains - Area(s)?

___ Bone Fractures/Osteoporosis Areas?

___ Spasms/Cramps Areas?

___ Tingling/Numbing in Arm/Hand

___ Tingling/Numbing in Leg/Foot

___ Pain in Head/Neck/Head Traumas #?

___ Pain in Jaw/TMJ/Orthodontia

___ Pain in Shoulder/Frozen/Rotator Cuff

___ Pain in Arm/Hand/Carpal Tunnel

___ Pain in Back/Hip/Scoliosis/Sciatica

___ Pain in Leg/Knee/Ankle/Foot/Fasciitis

___ Disk Injuries/Joint Fusions

___ Joint Replacements/Organ Transplant

___ Cosmetic Surgery/Implant/Prosthetic

___ Orthotics/Heel Lift/Dentures/Contacts

How much do you consume of:	Heavy	Moderate	Light	None
Caffeine	____	____	____	____
Sugar	____	____	____	____
Alcohol	____	____	____	____
Bread/Pasta	____	____	____	____
Dairy	____	____	____	____
Nicotine	____	____	____	____
CBD/THC	____	____	____	____

Please list ALL impact injuries, traumas or surgeries. Past & Present. Dates can be approx.

_____

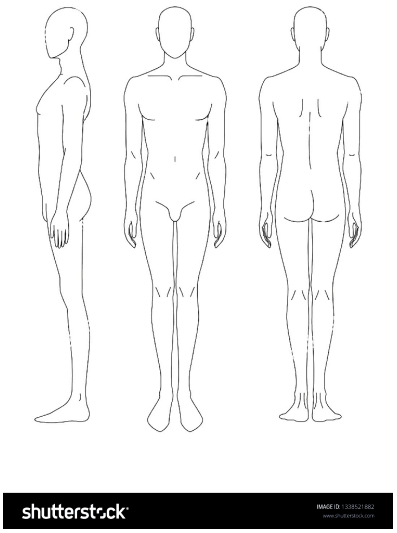
_____

_____

_____

_____

Use the diagram below to mark any specific body areas experiencing pain, tension, stress:



LIABILITY WAIVER

I,_____understand that the purpose of Massage Therapy, Holistic Healing & Optimal Wellness Support is to care for my overall health and well-being and is not a substitute for medical care. The Therapist does not diagnose illness or prescribe medication. I release the Therapist from any liability regarding any conditions I may have at anytime. I have stated all my known medical conditions and I will update the Therapist on my health status when applicable.

Signed: _____ Date: _____