Health History Information

Bryant Chiropractic and Massage - Ekaterina Bryant, LMP - Lic# MA00021223
12443 Bel-Red. Road, Suite 310, Bellevue, Washington 98005 Phone: 425-890-8983, email: kate@massagetherapy.com

Referred By: _____

Client Name: _____ Date of Birth: _____ Phone: _____

Address:_____ City and State: _____ Zip Code: _____

E-mail: _____ Gender: ☐ Male ☐ Female Occupation: _____

Emergency contact: _____ Phone: _____

Physician/Health-care Provider: _____ Phone: _____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? ☐ Yes ☐ No

Do you have a physician referral/prescription? ☐ Yes ☐ No Are you seeking insurance reimbursement? ☐ Yes ☐ No

Type of insurance coverage: ☐ Car Collision ☐ Worker's Compensation ☐ Private Health Insurance Name _____

Have you ever received professional massage/bodywork before? ☐ Yes ☐ No How recently? _____

What types of massage/bodywork have you received? _____What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

List and prioritize your current symptoms/issues (pain, stiffness, numbness/tingling, swelling, stress, etc)

_____

Do these symptoms interfere with your activities of daily living and which ones (e.g., sleep, exercise, work, childcare)?

_____

List any medications you currently take: _____

Are you wearing contacts? ☐Yes ☐No Are you wearing dentures? ☐Yes ☐No Are you wearing a hairpiece? ☐Yes ☐No Are you pregnant? ☐ Yes ☐ No

Health History

Have you had any recent or past injuries or surgeries? Please, list them below: _____

_____

Please, circle if you have any of the following conditions - blood clots, infections, congestive heart failure, contagious diseases, pitted edema.

Please indicate conditions that you have or have had in the past:

☐ Yes ☐ No Cancer _____	☐ Yes ☐ No Scoliosis
☐ Yes ☐ No Stroke, heart attack, circulatory problems	☐ Yes ☐ No Kidney disease, infection
☐ Yes ☐ No High/Low blood pressure	☐ Yes ☐ No Endocrine/thyroid conditions
☐ Yes ☐ No Epilepsy, seizures	☐ Yes ☐ No Neurological (e.g. MS, Parkinson's, chronic pain, Fibromyalgia)
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Digestive conditions (e.g. Crohn's, IBS)
☐ Yes ☐ No Swelling _____	☐ Yes ☐ No Gas, bloating, constipation
☐ Yes ☐ No Bruise easily	☐ Yes ☐ No Memory Loss, confusion, easily overwhelmed, insomnia
☐ Yes ☐ No Varicose veins	☐ Yes ☐ No Depression, anxiety
☐ Yes ☐ No Allergies: What kind? _____	☐ Yes ☐ No Dizziness, ringing in the ears
☐ Yes ☐ No Shortness of breath, asthma	☐ Yes ☐ No Headaches, Migraines
☐ Yes ☐ No Osteoporosis	☐ Yes ☐ No Numbness or tingling. Where? _____
☐ Yes ☐ No Degenerative spine/disk disease	☐ Yes ☐ No Muscle or joint pain and stiffness
☐ Yes ☐ No Arthritis (rheumatoid, osteoarthritis)	☐ Yes ☐ No Sensitive to touch/pressure
☐ Yes ☐ No Broken bones _____	Other Medical Conditions:_____

Consent for Treatment: If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____