# Confidential Client History

Simplicity
Acupuncture and Holistic Health

**Name** **Date of birth (dd/mm/yyy)**

**Address** **City** **Postal Code**

**Phone** **Email**

**Height** **Weight** ☐ **Male** ☐ **Female**

## General

**Occupation**

**Sports**

**Hobbies**

**Describe your sleep patterns**

**Do you have difficulty lying in a certain position?**

**List surgeries in last 5 years**

**List any serious or lasting trauma**

**Explain any other health or medication information**

**Have you had massage before?**

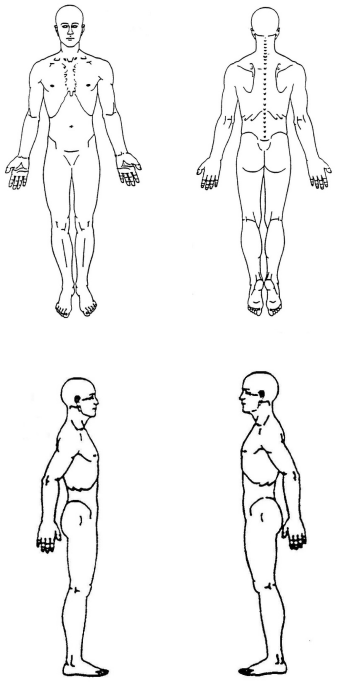
☐ **Yes** ☐ **No**

**What was your experience?**

**Are you receiving treatment from any other health care professional?**

☐ **Physician** ☐ **Physical Therapist**
☐ **Acupuncture** ☐ **Chiropractor**
☐ **Naturopath** ☐ **Other:**

**Please indicate on the diagram where you are experiencing any soreness or concerns:**



## Indicate conditions currently or recently experienced

### Infectious Conditions (present day)

☐ **Skin** *(rash, warts, open sores, herpes, or similar)*
☐ **Respiratory** *(common cold, bronchitis)*
☐ **Systemic** *(hepatitis, HIV/AIDS, flu, or similar)*

**Medications taken for these conditions**

**Comments**

### Skin Condition (non-contagious)

☐ **Eczema** ☐ **Psoriasis** ☐ **Contact allergies**

**Medications taken for these conditions**

**Comments**

**Please inform your therapist if you are currently experiencing a "flare-up" of any infectious condition.**

## Cardiovascular

- ☐ **High blood pressure**
- ☐ **Low blood pressure**
- ☐ **Phlebitis**
- ☐ **Stroke**
- ☐ **Chronic congestive heart failure**
- ☐ **Heart atack**
- ☐ **Varicose Veins** *(not spider veins)*
- ☐ **Heart disease** *(heart valve, pacemaker, or similar device)*

**Medications taken for these conditions**

**Comments**

## Head and Neck

- ☐ **History of stress headache**
- ☐ **History of migraine headach**
- ☐ **Dizziness**
- ☐ **Vision problems**
- ☐ **Vision loss**
- ☐ **Hearing problems**
- ☐ **Hearing loss**

**Medications taken for these conditions**

**Comments**

## Muscle/Joint/Bone

- ☐ **Fractures/sprains**
- ☐ **Rheumatoid arthritis**
- ☐ **Osteoarthritis**
- ☐ **Osteoporosis**
- ☐ **Scoliosis**
- ☐ **Wires/plates/pins**

**Medications taken for these conditions**

**Comments**

## Respiratory

- ☐ **Allergies**
- ☐ **Asthma**
- ☐ **Bronchitis**
- ☐ **Chronic cough**
- ☐ **Shortness of breath**
- ☐ **Emphysema**

**Medications taken for these conditions**

**Comments**

## Digestive

- ☐ **Crohn's disease**
- ☐ **Colitis**
- ☐ **IBS**
- ☐ **Constipation**
- ☐ **Ulcers**
- ☐ **Liver disease**

**Medications taken for these conditions**

**Comments**

## Other Conditions

- ☐ **Diabetes**
- ☐ **Kidney Disease**
- ☐ **Chronic Fatigue**
- ☐ **Fibromyalgia**
- ☐ **Cancer**
- ☐ **Epilepsy**
- ☐ **Hemophilia**
- ☐ **Other:**

**Medications taken for these conditions**

**Comments**

## Women Only

- ☐ **Menstural problems**
- ☐ **Menopausal problems**
- ☐ **Gynecological problems**
- ☐ **Pregnancy due date:**
- ☐ **Pregnancy complications**

**Medications taken for these conditions**

**Comments**

## Waiver

I verify that the information I have provided is complete and true to the best of my knowledge and therefore release the massage practitioner from any and all liability as a result of information not given, or incorrectly given in this confidential client history. I understand that the information I have provided is confidential between myself and my massage therapist and will only shared with other health care providers if I have given written consent.

**Name**

**Signature**

**Date**

# Terms and Conditions

I understand that the therapist has the right to refuse treatment if deemed medically unsafe by the therapist. The therapist has the right to modify treatment based on any presenting contraindications. I understand that this is for my safety and wellbeing.

I understand that it is my responsibility to keep my therapist updated on any changes to my medical history and medication use.

I understand that orthopedic assessment is necessary for the therapist to perform safe and effective treatment. I understand that if I choose to reject orthopedic assessment, my treatment will consist of relaxation massage only.

I understand that the therapist is not a physician and does not diagnose illness, disease, or any other physical or mental disorder, and that their findings should not be taken as such. The therapist may refer me to other health care practitioners that they feel may benefit my treatment, however, it is my choice as to whether I see that practitioner or not.

I understand that I will not attend my appointments under the influence of drugs and/or alcohol. I acknowledge that if my therapist suspects that I am under the influence, no treatment will be given and I will be asked to leave.

I understand that there is zero tolerance for any and all inappropriate and abusive language or behavior. This incudes sexual comments and inappropriate touch, sexist or racist comments, or other offensive language. I understand that my treatment will be terminated immediately and I will be asked to leave. I understand that I will still have to pay the full fee of my appointment, regardless of when treatment was terminated.

I understand that under no circumstances should any of the techniques used cause discomfort that is not easily tolerable and/or surpass a 7 on a 1-10 pain scale. I will notify my therapist immediately if any pain is experienced. As with any manual therapy, there can be risks, and I assume those risks.

I understand that the services provided will be submitted to my insurance provider on my behalf, however, this does not guarantee payment. It is my responsibility to ensure eligibility and to know my maximums. I understand that I will be responsible to pay any remaining balance on my account.

By signing below, I verify that I have carefully read and understand the terms and conditions listed above. I have had the opportunity to ask any and all questions I may have had and they have been answered to my satisfaction.

**Signature** _____

**Name** _____ **Date** _____