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?

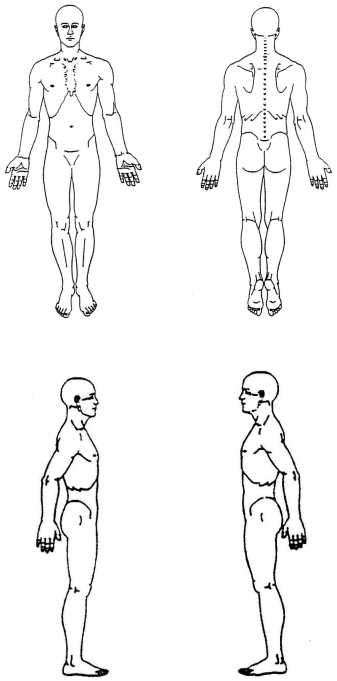
Are you receiving treatment from any other health care professional?

☐ **Physician** ☐ **Physical Therapist**

☐ **Acupuncture** ☐ **Chiropractor**

☐ **Naturopath** ☐ **Other:**

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



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

I understand that the therapist is currently a student and will only work within their current scope of practice. I acknowledge that with any treatment there can be risks and and I assume those risks.

I understand that while the therapist is still a student, I will be unable to submit my service to most insurance companies and will be responsible for paying the full fee.

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** _____