CLIENT HISTORY FORM

Name:_____ Date:_____

Address:_____ Email:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Height:_____ Weight:_____ Age:_____ # of Children:_____ Occupation:_____

Emergency contact:_____ Relationship:_____ Phone #_____

Who referred you to this office?_____

Method of payment: (circle one) cash check credit card *(MC, Visa, AMEX)*_____

Who is responsible for payment (if not you)?_____

* *

Are you taking a blood thinner? N Y – name:_____

(PLEASE NOTE: we cannot do bodywork on you if you are taking prescription blood thinners – aspirin is not a problem? Blood thinner medication is not an issue for breathwork)

Describe major complaint:_____

_____

When and how did your condition develop?_____

_____

What makes your condition worse?_____

_____

List diagnosis (if known) and current treatment:_____

_____ *(If available, please bring current reports: MRI, X-rays, Medical)*

Are you currently under doctor care? N Y – please explain:_____

_____

If auto accident, give date and escription:_____

_____

Head Injuries: N Y (approximate dates) _____

_____

All surgeries & serious illnesses - approximate year:_____

_____

Results from previous massage treatments:_____

Dental work: Dentures? N Y – full___, partial___; Implants: N Y; Bridge: N Y – permanent____, removable____

Do you wear contact lenses? N Y Do you wear orthotics or heel lift? N Y

Have you had cosmetic face surgery? N Y (Please explain):_____

List **ALL** current medications and their purpose:_____

_____

Do you have any skin disorders or allergies (i.e. latex)? N Y – please explain:_____

_____

Do you regularly drink caffeine beverages (coffee, tea, sodas, etc.) N Y – frequency_____

Do you smoke? N Y – how much?_____

Are you pregnant? N Y – estimated due date?_____

Are you participating in a regular fitness program? N Y – please describe:_____

_____

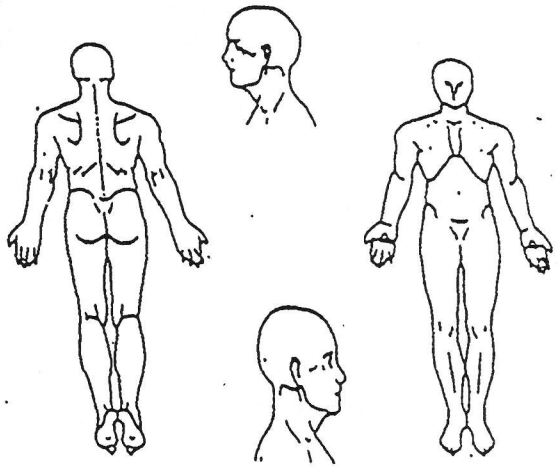
Do you have any other medical condition or physical limitation that I need to know before you receive this bodywork?

N Y – please explain:_____

Please circle any of the following that apply, present or past:

AIDS (or HIV related
Abdominal hernia
Hiatal Hernia
Acid Reflux
Stomach Disorders
Constipation
Diarrhea
Arthritis
Bursitis
Diabetes
Cancer
Shortness of Breath
Chest Pain
Heart Conditions
Low Blood Pressure
High Blood Pressure
Varicose Veins
Blood Clots
Dizziness
Loss of balance
Fainting Spells
Ears Ring
Edema
Severe Irritability
Severe Depression
Severe Menstrual Pain
PMS
Fatigue
Broken Bones
Herniated Disc
Headaches
Sinusitis
TMJ
Neck Pain
Back Pain
Sciatic Pain
Knee Pain
Feet Cold
Foot Numbness
Foot Pain
Shoulder Pain
Arm / Elbow Pain
Carpal Tunnel
Hand Numbness
Hands Cold
Scoliosis

PLEASE SHADE IN ALL AREAS OF PAIN



I have listed ALL my known medical conditions, physical limitations, and medications. **I will inform my therapist of any changes in my physical health or medications.** I understand that a licensed massage therapist does not diagnose illness, disease, or any other medical, physical or psychological disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any problems that I have.

I agree to pay for all services at the time they are rendered, unless prior arrangements have been made.

CANCELLATIONS and MISSED APPOINTMENTS: Unless you are ill or have an emergency, we require 24 hr. notice for any schedule changes, or you may be responsible for the full session fee. We cannot do bodywork sessions if you are sick. If there is a question, please call.

I understand the information contained herein is privileged and confidential. I authorize the release of any information pertaining to my health to my attorney, insurance company, or referring physician / therapist.

INSURANCE COVERAGE: Our prescription form completed by your physician must be on file prior to treatment. I will give you the forms to file to your insurance company after payment has been made.

Signature:_____ Date:_____

If client is a minor, signature of parent/guardian:_____

INFORMED CONSENT

I (print client name)_____understand that Structural Energetic Therapy7 (hereafter referred to as SET) is a therapeutic and rehabilitative therapy for musculoskeletal problems.
I understand that the SET Practitioner is highly trained in advanced SET Techniques and that SET treatment is unique, and is not like other massage treatments I may have had.

I understand that, due to its structural nature, it will be necessary for my structural alignment to be observed while standing with most of my body visible to the examiner.

I understand that the SET Practitioner will ask me to participate in the evaluation process by using structural observation, kinesiology, and an interview that may include questions about health history, current medications, and life style.

I agree to keep the SET Practitioner updated on any changes in the status of my health.

I agree to inform the SET Practitioner of <u>any and all medication changes</u> that occur throughout the duration of my SET treatments.

I understand that the optimum number of SET sessions will be determined by the SET Practitioner in order to achieve the rehabilitation goals based on my condition.

I understand that the SET Practitioner may at any point in the treatment, using his/her professional judgement, decide that I have reached my limit for that particular treatment.

I understand that it is my responsibility to communicate to the SET Practitioner if I feel I have reached the end of my tolerance for SET Therapy within any given session.

I give my permission to the SET Practitioner to move clothing aside when necessary in order to work on soft tissue that would usually be covered by a bathing suit (genitals will not be exposed and modesty will be respected). When the therapist explains the reason for working specific soft tissue, I agree to communicate to the therapist if it is NOT okay for the area to be either touched or exposed for treatment (such as hips, gluteals).

I understand that payment is due in full upon completion of the session unless other arrangements have been made.

I understand that if I do not cancel a scheduled appointment at least 24 hours in advance (barring emergencies) I am responsible for paying the full fee for that time.

Client Signature:_____Date:_____

Signature of parent/guardian if appropriate:_____