ahimsa healing

# CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

E-Mail: _____ Referred by: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Do you exercise?: _____ What do you do?: _____ How often?: _____

Current medications: _____

Are you currently experiencing any of the following conditions? Please check (√)

Flu or Cold ___ Inflammation ___ Fever ___ Infection ___ Contagious Disease___

Any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

## CIRCULATORY SYSTEM
__ Anemia
__ Hemophilia
__ Hypertension
__ Low Blood Pressure
__ Raynaud's Disease
__ Varicose Veins
__ Heart Condition
__ Blood Clots/Phlebitis
__ Diabetes
__ Swelling
__ Other_____

## DIGESTIVE SYSTEM
__ Ulcers
__ Irritable Bowel Syndrome
__ Colitis
__ Gallstones
__ Hepatitis
__ Crohn's Disease
__ Diarrhea
__ Gas/Bloating
__ Indigestion
__ Bleeding
__ Constipation
__ Difficulty swallowing
__ Other_____

## SKIN
__ Fungal Infections
__ Acne __ Impetigo
__ Dermatitis/Eczema
__ Psoriasis
__ Open Wound or Sore
__ Rashes
__ Warts/Moles
__ Athletes Foot
__ Other_____

## RESPIRATORY SYSTEM
__ Pneumonia
__ Sinusitis
__ Asthma
__ Trouble Breathing
__ Other_____

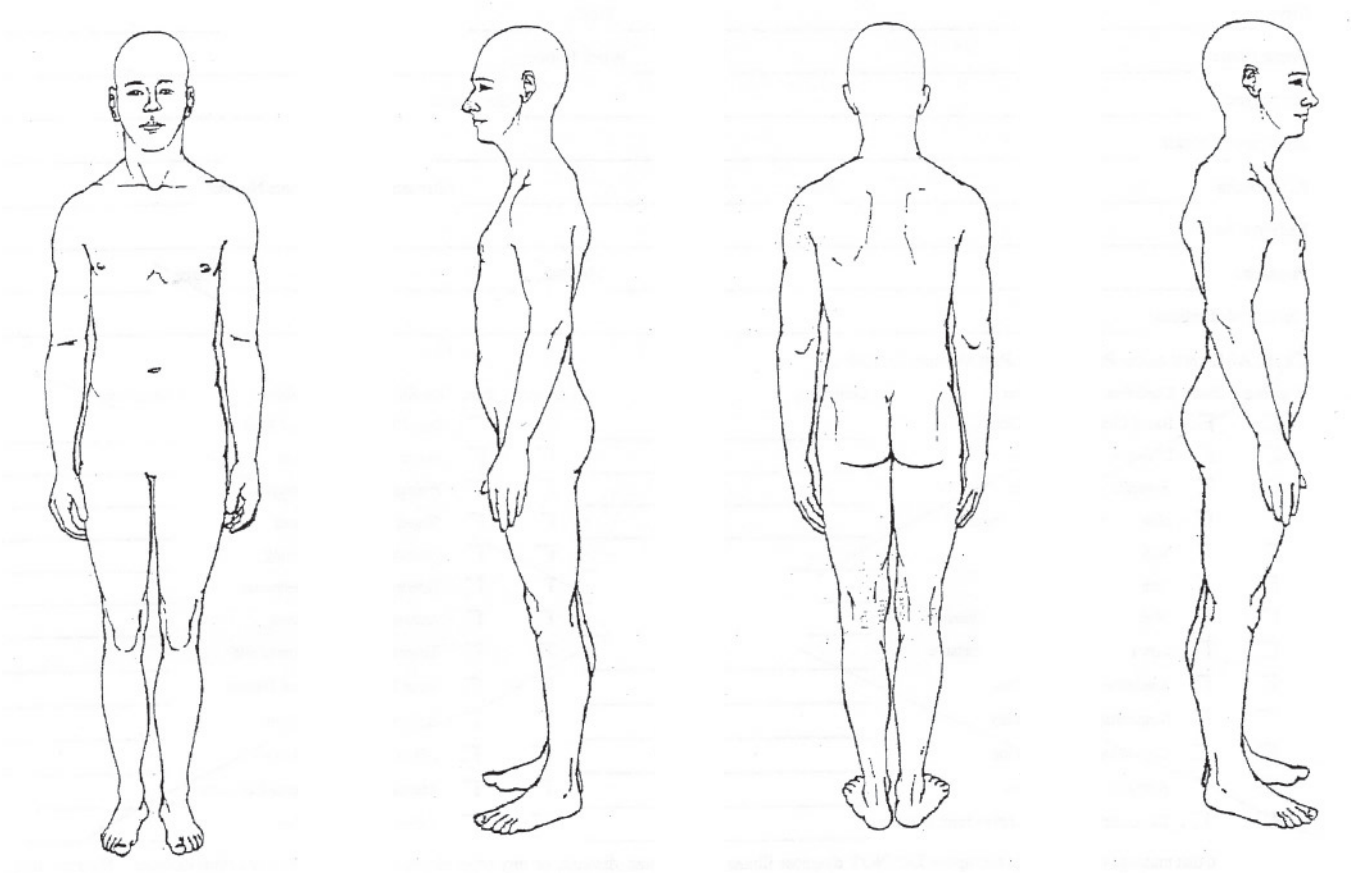
## MUSCULOSKELETAL SYSTEM
__ Fibromyalgia
__ Spasms/Cramps
__ Sprains/Strains
__ Osteoporosis
__ Gout
__ Osteoarthritis/Rheumatoid Arthritis
__ TMJ
__ Cysts
__ Bursitis
__ Plantar Fascitis
__ Tendonitis
__ Whiplash Syndrome
__ Carpal Tunnel Syndrome
__ Sciatica
__ Thoracic Outlet Syndrome
__ Leg Pain
__ Arm Pain/Shoulder Pain
__ Low Back Pain
__ Mid Back Pain
__ Hip Pain
__ Other_____

## NERVOUS SYSTEM
__ ALS
__ Multiple Sclerosis
__ Parkinson's Disease
__ Bell's Palsy
__ Neuritis
__ Spinal Cord Injury
__ Stroke
__ Trigeminal Neuralgia
__ Seizure Disorders
__ Numbness/Tingling/Twitching
__ Dizziness
__ Other_____

## OTHER
__ Insomnia
__ Sleep Apnea
__ Anxiety/Panic Attacks
__ Physical/Emotional Abuse
__ Substance Abuse
__ Grief Process
__ Cancer
__ Chronic Fatigue Syndrome
__ HIV/AIDS
__ Lupus
__ Kidney Disease
__ Bladder Infection
__ Depression
__ Migraines
__ Frequent Headaches
__ Ear/nose/throat infection
__ Glaucoma
__ Visions problems
__ Other_____

Mark below as indicated:

"P" for areas of pain.
"X" for joint/muscle stiffness.
"N" for areas of numbness/tingling.
"S" for swelling



I understand that massage therapists DO NOT diagnose illness, disease, or any other physical or mental disorder. Nothing that is said or done should be misconstrued as such. Massage therapy is not a substitute for medical examination and/or diagnosis.

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my massage therapist updated on my physical health. I also agree that there shall be no liability on the practitioner's part should I neglect to do so.

CONSENT FOR CARE: It is my choice to receive massage therapy. I give my consent to receive treatment. I understand that I may withdraw this consent at any time during the treatment, for any part of the treatment, for any reason. 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 in full.

I agree that cancelled or missed appointments without 48 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Would you like an appointment reminder?: ☐ Yes ☐ No ☐ Phone call ☐ E-Mail ☐ Text message

Signature: _____ Date: _____

Signature of parent or guardian: _____ Date: _____

(For clients under 18 yrs, parent/guardian signature is required for treatment.)