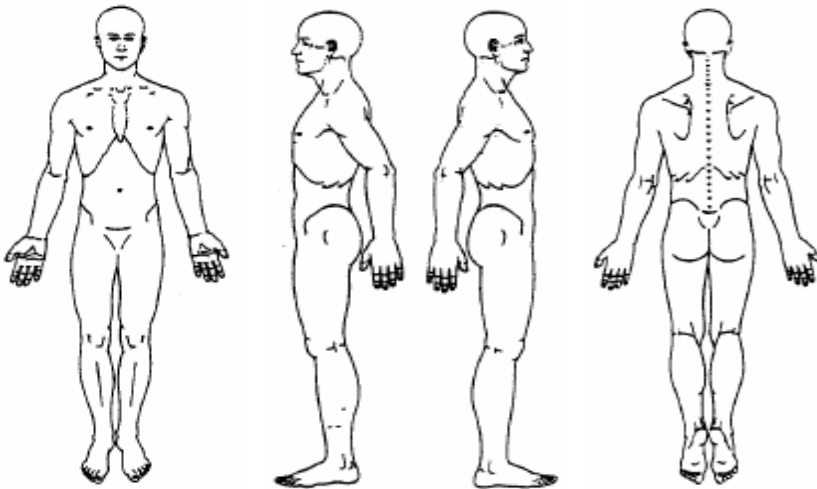


Inspirit Therapies: Body, Mind, Spirit

Confidential Health History (Initial Visit)

Name: _____ Physician: _____
Address: _____ Home Phone: _____
City/State: _____ Zip Code _____ Work Phone: _____
Date of Birth: _____ Occupation: _____ Gender: M ___ F ___
Marital Status: S / D / M Children #: _____
Pregnant: Y / N Wk/Mo: _____ If yes, **must** have **Physician Approval** for massage? Y / N
Eye Contacts: Y / N Any Allergies: Y / N _____ (more room to list on page 2)

Have you had a massage before? Y / N How long ago? _____ Referred by? _____
If yes, what type: ___ Swedish (relaxation) ___ Specific Therapeutic (Trigger Point / with Swedish)
What type of pressure do you like?(please check) ___Mild ___Moderate ___Deep ___Not Sure



Circle any areas you are currently or chronically experiencing pain or tension.

Rate the pain between 1– 10.
1- Low to 10 - Excruciating
For example: 4/10 or 6/10

Then **write** pain rating in the circled areas.

For Therapeutic Massage:

Major symptoms? What brought it on? What aggravates it? What have you done for relief?

Is it getting worse? Y / N Does the pain travel? Y / N Time most severe: **AM / PM**

Have you seen a **Chiropractor/ Doctor (Name)**? Y / N _____

Doctor Diagnosis/recommendations? _____

All Clients:

Please check or add other symptoms you may be **chronically or currently** experiencing:

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shoulder tightness | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins & needles in arms/hands | <input type="checkbox"/> Pain in legs or feet |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Sciatica /Hip Pain |
| <input type="checkbox"/> Head feels heavy | <input type="checkbox"/> Painful / Swollen Joints | <input type="checkbox"/> Bulging/Herniated Vertebrae |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest Pains | ? Cervical ___Thoracic ___Lumbar___ |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Arthritis | Other _____ |
| <input type="checkbox"/> Heart Pain / Palpation | <input type="checkbox"/> Light bothers eyes | Other _____ |

PRIOR HEALTH INFORMATION

(Please be thorough)

Check all those that apply and please give details as necessary.

- Z High Blood Pressure: (doctor care/medication? Y / N) Z Heart Condition: (doctor clearance? Y / N)
Z Diabetes: (doctor clearance? Y / N) Z Phlebitis: Where? _____ Z Varicose Veins
Z Cancer: (doctor clearance? Y / N) (Past / Present) Where? _____
Z Arthritis (Type): _____ Z Allergies:(list) _____
Z Infectious/Communicable Diseases :(list) _____ Z Warts: Hands / Feet

Please detail current treatments and medications for above or any medical issues?

	Date	Doctor/Hospital	Diagnosis	Treatment/Medications
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Please list any injury, accident or surgery (especially cervical or spinal):

	Date	Doctor/Hospital	Diagnosis	Treatment
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Any Other Medications? _____ Do you take Vitamins, Minerals, Herbs? Y / N

Exercise/ sports/ self-care routine? _____

How often? _____ Do you stretch? Y / N Regularly? Y / N

Describe any other physical complaints, problem areas, or comments: _____

INSPIRIT THERAPIES OFFICE POLICIES: (PLEASE READ BEFORE SIGNING)

- 1) I certify that the **above information is complete and correct**. I know of **no ailments to prevent me from receiving therapeutic massage** and will not hold the Therapist responsible for injury sustained.
- 2) I have consulted and have **received my doctor's clearance** to receive massage for any health issues for which I am under continued doctor's care. (Heart problems, High Blood Pressure, Diabetes, Phlebitis, Pregnancy, Cancer...)
- 3) I will continue to **keep the massage therapist informed of any changes** as they occur.
- 4) I will **not begin exercises or stretches without first consulting my physician for advice**. In addition, the therapist will not be liable for injury sustained during exercises or stretches to be performed.
- 5) I have been **informed of the treatment fee**, and understand I **am responsible for full payment** at the time of treatment unless other prior arrangements have been made.
- 6) I agree to give **24 hours notice for canceling/rescheduling** an appointment. Extreme emergencies are considered.
- 7) If I am **late for an appointment**, I understand I will **receive the balance of time left** for my appointment.
- 8) My **privacy is important** and will be held confidential within the boundaries of the law.
- 9) I have **read and accept** the statements within **Inspirit Therapies' Code of Ethics**.
- 10) I have **read the above policies and have received a copy of Inspirit Therapies office policies**.

Client Signature: _____ **Date:** _____

Please do not write below (Therapist comments only)

