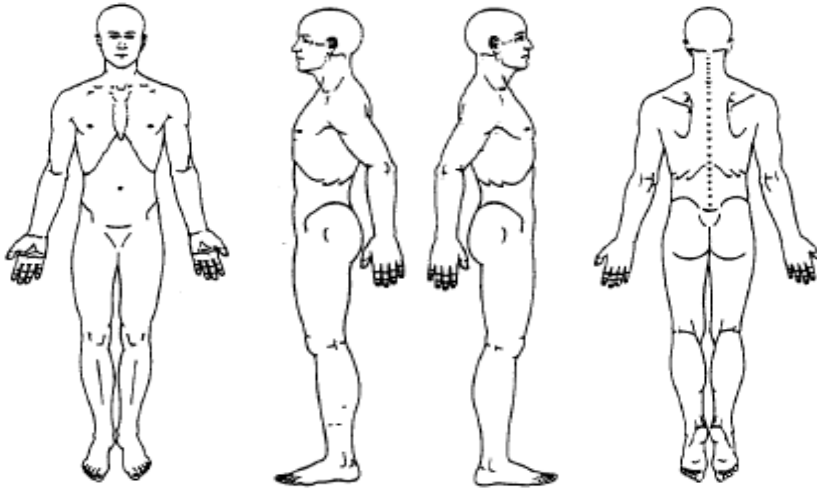


# Inspirit Therapies: Body, Mind, Spirit

## Confidential Health History (Initial Visit)

Name: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City/State: \_\_\_\_\_ Zipcode \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Birth date : \_\_\_\_\_ Occupation: \_\_\_\_\_ Email: \_\_\_\_\_  
 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?

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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.**

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

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(If client under 18 years of age parental signature required)

**Please do not write below (Therapist comments only)**

\_\_\_\_\_  
\_\_\_\_\_