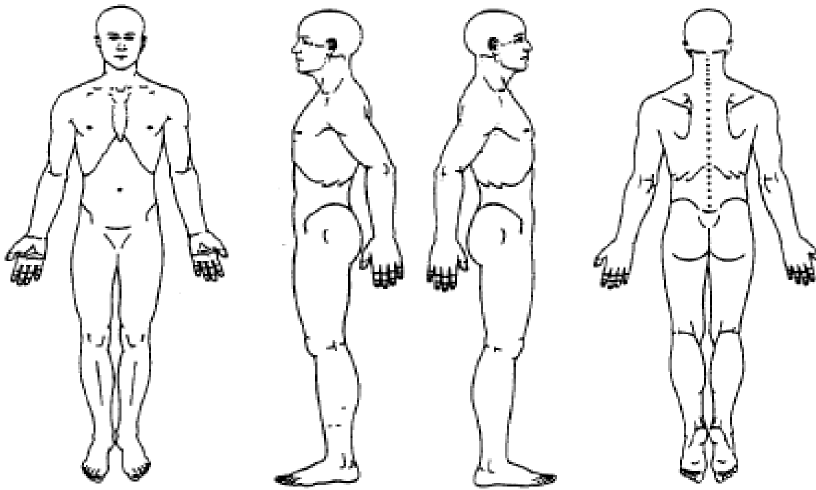
Inspirit Therapies: Body, Mind, Spirit

Confidential Health History (Initial Visit)

Name: ___________________________________ **P**hysician: ________________________
Address: ___________________________________ **H**ome Phone: _______________________
City/**S**tate: ________________ **Z**ipcode _________ **W**ork Phone: ______________________
Birth date : _____________ **O**ccupation: _________________ **E**mail**:** __________________
Gender: M ____ F ____ **M**arital Status: S / D / M **C**hildren #: _______
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 **H**ow long ago?______ **R**eferred by?______________
If yes, what type: ___ Swedish (relaxation) ___ Specific Therapeutic (Trigger Point / with Swedish)
What type of pressure do you like?(please check) ___**M**ild ___**M**oderate ___**D**eep ___**N**ot 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? **W**hat brought it on? **W**hat aggravates it? **W**hat have you done for relief?
____
____
____

Is it getting worse? Y / N **D**oes the pain travel? Y / N **T**ime 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:

__ Headaches
__ Neck Pain
__ Sinus trouble
__ Head feels heavy
__ Dizziness
__ Muscle spasms
__ Heart Pain / Palpation

__ Shoulder tightness
__ Pins & needles in arms/hands
__ Chest pains
__ Painful / Swollen Joints
__ Chest Pains
__ Arthritis
__ Light bothers eyes

__Pinched nerves in back
__Pain in legs or feet
__Sciatica /Hip Pain
__Bulging/Herniated Vertebrae
? Cervical __Thoracic __Lumbar__
Other ___________________
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)

____
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