

Facilitated Healing, LLC

Confidential Client Health History/Bodywork Intake Form

Please fill out completely and as clearly as possible.

Name: _____ E-Mail: _____

Address: _____

City: _____ State: _____ Zip: _____ D/O/B: _____ Occupation: _____

Phone (Home) _____ (Cell) _____ OK to leave message? Home: yes/no Cell: yes/no

Referred By: _____ Chiropractor: _____ Physician: _____

Person to contact in emergency: _____ Relationship: _____ Telephone: _____

Primary Goal(s) for Appointment: _____

When was your last professional massage? _____ How often do you receive massage? _____

Are there any areas that you wish the therapist to avoid? _____

List any medications, including over-the-counter and nutritional supplements, you are taking and what you are taking them for:

Current Height: _____ Current Weight _____ Smoke? _____ Alcohol? _____

Daily water intake? (ounces) _____ Have you ever been treated for cancer? yes / no Type: _____

Are you a loud and/or regular snorer? yes / no

Have you been observed to gasp or stop breathing during sleep? yes / no

Are you often tired or fatigued during the wake time hours? yes / no

Do you fall asleep sitting, reading, watching TV, or driving? yes / no

Do you often have problems with memory or concentration? yes / no

Do you feel tired or groggy upon waking, or do you awaken with a headache? yes / no

Have you ever experienced: Physical Abuse? yes / no Emotional Abuse? yes / no Sexual Abuse? yes / no

Other Traumas? _____

Health History: Please check any of the following conditions that you have frequently or are currently experiencing:

*Are you Diabetic or have other blood sugar issues? _____

Cardiovascular:

_____ High/Low Blood Pressure (please circle High/ Low)

_____ Heart Disease

_____ Poor Circulation

_____ Varicose Veins

_____ Blood Clot(s): When: _____

_____ Other

Muscles/Joints:

_____ Osteoporosis

_____ Arthritis

_____ Joint Swelling

_____ Degenerative Disc

_____ Other

Head:

_____ Headaches (Type and how often?) _____

_____ Contact Lenses

_____ Dentures

_____ Sinus Conditions

_____ Other

Skin:

_____ Allergies to oils, lotions, etc.

_____ Skin Condition(s) _____

_____ Bruise Easily

_____ Open Wounds

_____ Other

Women:

_____ Pregnant _____ Weeks

_____ Any Health Restrictions: List: _____

_____ PMS

Respiratory:

_____ Breathing Condition(s): _____

_____ Other

Injury(s):

Type(s): _____
 Date(s): _____
 Current Symptoms: _____

Regular Exercise/Sports:

What Kind(s): _____
 How Often: _____

Current Treatments: (i.e. Physical Therapy)

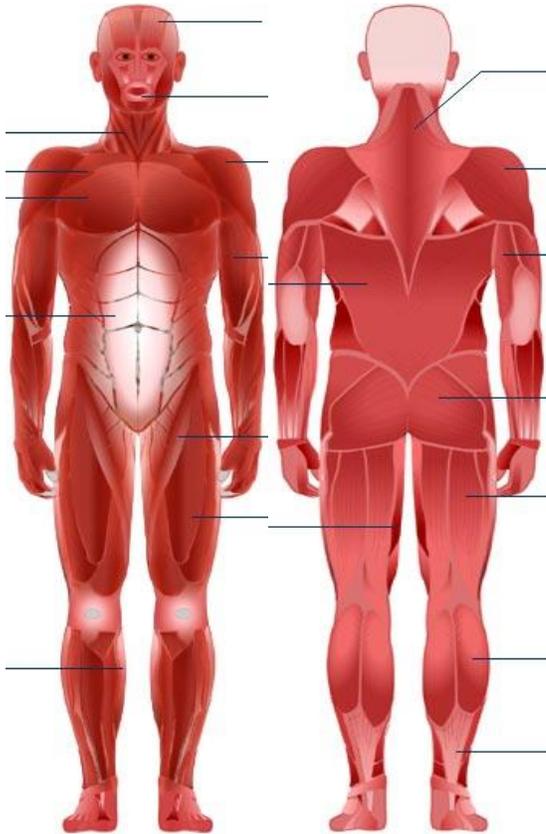
What Kind(s): _____
 How Often: _____

Anything else you want us to know? _____

Surgery(s):

Type(s): _____
 Date(s): _____
 Current Symptoms: _____

Please check areas where you are experiencing pain, tension, or stiffness and rate pain using this scale:



<u>Pain Level</u>	<u>Description</u>	<u>Comments</u>
10	● TOTALLY DISABLING Must take care of pain.	
8	● SEVERE, Can't concentrate and can't do all but simple things.	
6	● DISTRESSFUL, But able to continue some physical activity.	
4	● TOLERABLE, Can be ignored somewhat.	
2	● MILD, Only aware of pain when focused on.	
0	● PAIN FREE	

I understand that the services I am requesting and hereby authorize by Facilitated Healing, LLC practitioners are intended to enhance relaxation, reduce pain/tension, increase range of motion, improve circulation, and offer a positive experience of touch. I am aware that the practitioner does not diagnose illness or disease, and does not prescribe medication. I am also aware that spinal manipulations are not a part of massage therapy/bodywork. I will inform the practitioner of all of my physical and medical conditions, along with any current medications, and I will keep the practitioner updated on any changes to this information while under their care. I agree that I am responsible for any damages or injuries resulting from my failure to provide accurate information about my health status.

Client Signature: _____

Date: _____

Therapist Signature: _____

Date: _____

Consent to treat a Minor

With my signature I authorize a licensed practitioner to provide massage therapy/bodywork to my child or dependent.

Signature of parent or guardian: _____

Date: _____