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 wakening, 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:

Cardiovascular:

_____High Blood Pressure
_____Low Blood Pressure
_____Poor Circulation
_____Heart Disease
_____Blood Clot(s): When:_____
_____Varicose Veins

Skin:

_____Allergies to oils, lotions, etc.
_____Skin Condition(s)
Type:_____
_____Open Wounds
_____Bruise Easily

Respiratory:

_____Breathing Condition(s):
Type:_____

Muscles/Joints:

_____Osteoporosis
_____Arthritis
_____Joint Swelling
_____Degenerative Disc

Head:

_____Headaches
Type:_____How Often:_____
_____Contact Lenses
_____Dentures
_____Sinus Conditions

Women:

_____Pregnant _____Weeks
_____Any Health Restrictions: List:_____
_____PMS

Injury(s):

Type(s):_____

Date(s):_____

Current Symptoms:_____

_____

Surgery(s):

Type(s):_____

Date(s):_____

Current Symptoms:_____

Regular Exercise/Sports:

What Kind(s):_____

How Often:_____

Current Treatments: (i.e. Physical Therapy)

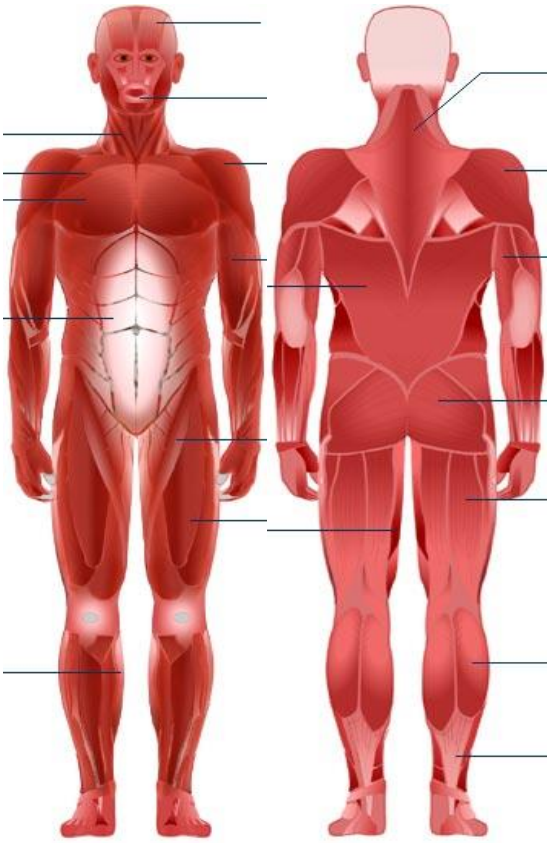
What Kind(s):_____

How Often:_____

_____

_____

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



Pain Level	Description	Comments
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:_____

Revised Dec 2017