

WELCOME

Client Information

Please Print Clearly

Date: _____ Referred by Whom? _____

Full Name: _____

Address: _____

City: _____ State: _____

Zip: _____ Email: _____

Sex: M F Age: _____ Birthdate: _____

Height: _____ Weight: _____ Minor Single Married

Widowed Separated Divorced Partnered for _____ years

Occupation: _____

Parental Consent For Minors

I, _____ the undersigned parent of _____, a minor, do hereby consent to them participating in therapeutic/Athletic massage.

Parent's Signature: _____

Phone Numbers

Home Phone: (____) _____

Cell Phone: (____) _____

Work: (____) _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name: _____

Relationship: _____

Home Phone: (____) _____

Work Phone: (____) _____

Doctor's Name: _____

Doctor's Phone: (____) _____

Client's Health History

Reason for Visit: _____

What type of massage are you interested in receiving?

Therapy Sports/Stretching Stress Reduction Maintenance

If coming for Injury Therapy, is it due to a: recent or past injury?

How long ago was the injury? _____

Where exactly is the problem? Mark the figure to specify →

Rate the recent level of pain in the Pain Rating Scale.

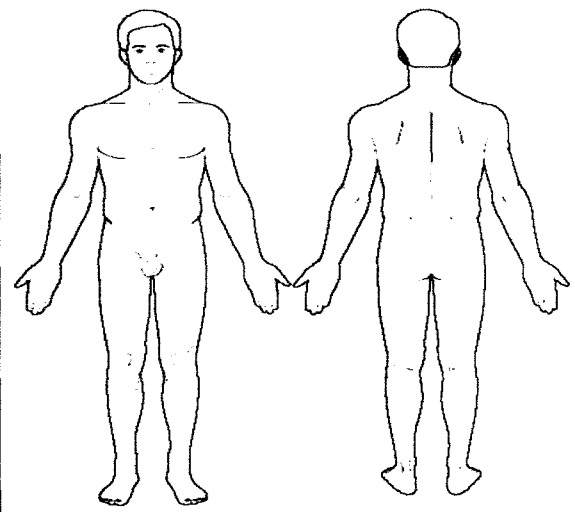
How does it feel? aching cramping dull sore deep sharp

shooting stabbing sting tingling burning numbness

radiating - If so, where? _____

How did it start the 1st time & this time, if this is not the first?

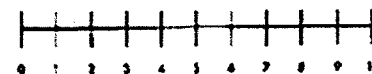
Onset of injury: sudden gradual How did it happen? _____



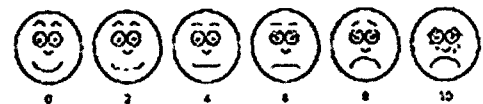
Anterior

Posterior

Pain Rating Scale



0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Worst possible pain



**Health History Continued...
Injury & Pain Information**

- How often does it bother you? constant all the time, everyday Comes & Goes
___ x per day ___ x per week ___ x per month
- How long does it last once it is there? Always There ___ Minutes ___ Hours No Pattern
- What specifically makes it worse? (Certain movements/activities, stress, time of day, no pattern)

- What makes it feel better? (Certain movements/activities, heat/ice, time of day, therapies, nothing)

- Do you have a diagnosis from a doctor? If yes, please list it and name of the doctor.

What treatment have you received for your condition? Medications Surgery Physical Therapy Massage
Therapy Chiropractic Accupuncture/ Accupressure none other: _____

What were the results of these Therapies? _____

- What do you believe caused or is causing this condition? _____

- Do you believe it is possible to heal 100%? If not, what %? _____

- How long do you feel it will take? _____

- Are there any specific areas you do NOT want the practitioner to touch? Please consider that in order to help you; we will need to have access to most of the body to access muscles, tendons and ligaments. Restrictions of palpation may inhibit us to help you the best we know how.: _____

- On a scale of 0-10, how much effort are you willing to put in to achieve maximum healing?

- Circle the level of stress you are experiencing on a regular basis on a scale of 1-10 (1 being the lowest)

1 2 3 4 5 6 7 8 9 10

Health History Continued Activities of Daily Living

Exercise	Work Activity	Habits
<input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Daily <input type="checkbox"/> Weekly _____ # of hours spent exercising per week?	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Repetitive <input type="checkbox"/> Desk/Computer work <input type="checkbox"/> Other: _____	<input type="checkbox"/> Smoking #/Day: _____ <input type="checkbox"/> Alcohol # Drinks/Week: _____ <input type="checkbox"/> Coffee/Soda/Tea oz/day: _____ <input type="checkbox"/> Water # glasses/day: _____ <input type="checkbox"/> High Stress Level Reason: _____
What types of exercise? _____ _____ _____		<h3 style="text-align: center;">Nutrition & Diet</h3> <input type="checkbox"/> Mixed food (animal & Vegetable sources) <input type="checkbox"/> vegetarian <input type="checkbox"/> vegan <input type="checkbox"/> salt restriction <input type="checkbox"/> fat restriction <input type="checkbox"/> starch/carb restriction <input type="checkbox"/> Zone Diet <input type="checkbox"/> total calorie restriction Specific food restrictions: <input type="checkbox"/> dairy <input type="checkbox"/> wheat <input type="checkbox"/> eggs <input type="checkbox"/> soy <input type="checkbox"/> corn <input type="checkbox"/> all gluten <input type="checkbox"/> peanuts <input type="checkbox"/> other: _____ Food Frequency: Servings per day of: Fruits (citrus, melons, etc): _____ Dark green or deep yellow/orange vegetables: _____ Grains (unprocessed): _____ Beans, peas, legumes: _____ Dairy, eggs: _____ Meat, Poultry, fish: _____
Do you stretch before your workouts? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you stretch after your workouts? <input type="checkbox"/> Yes <input type="checkbox"/> No		<h3 style="text-align: center;">Current Supplements</h3> <input type="checkbox"/> Multi-vitamin/ Mineral <input type="checkbox"/> Vitamin C <input type="checkbox"/> Vitamin E <input type="checkbox"/> EPA/DHA <input type="checkbox"/> Evening Primrose <input type="checkbox"/> Calcium source: _____ <input type="checkbox"/> Magnesium <input type="checkbox"/> Zinc <input type="checkbox"/> Minerals describe: _____ <input type="checkbox"/> Friendly Flora (acidophilus) <input type="checkbox"/> Digestive Enzymes <input type="checkbox"/> Amino Acids <input type="checkbox"/> CoQ10 <input type="checkbox"/> Antioxidants <input type="checkbox"/> herbs - teas <input type="checkbox"/> herbs - extracts <input type="checkbox"/> Chinese herbs <input type="checkbox"/> Ayurvedic herbs <input type="checkbox"/> Homeopathy <input type="checkbox"/> Bach Flower <input type="checkbox"/> Protein shakes <input type="checkbox"/> Bee Pollen <input type="checkbox"/> Liquid meals (E.g. Ensure) <input type="checkbox"/> Other: _____
<h3 style="text-align: center;">Eating Habits</h3> <input type="checkbox"/> Skip breakfast <input type="checkbox"/> 2 meals/day <input type="checkbox"/> 1 meal/day <input type="checkbox"/> Graze (small frequent meals) <input type="checkbox"/> Food rotation <input type="checkbox"/> Eat constantly, whether hungry or not <input type="checkbox"/> Generally eat on the run <input type="checkbox"/> Eating lots of snacks <input type="checkbox"/> Add salt to food <input type="checkbox"/> Add sugar to food/drink <input type="checkbox"/> Add Splenda to food/drink <input type="checkbox"/> Add Sweet'n'Low or Equal to food/drink (Aspartame products)		<h3 style="text-align: center;">Would you like to:</h3> <input type="checkbox"/> Have more energy <input type="checkbox"/> Be stronger <input type="checkbox"/> Have more endurance <input type="checkbox"/> Be Thinner <input type="checkbox"/> Be more muscular <input type="checkbox"/> Improve your complexion <input type="checkbox"/> Have stronger nails <input type="checkbox"/> Have healthier hair <input type="checkbox"/> Be less moody <input type="checkbox"/> Be less depressed <input type="checkbox"/> Sleep better <input type="checkbox"/> Be less indecisive <input type="checkbox"/> Feel more motivated <input type="checkbox"/> Be more organized <input type="checkbox"/> Think more clearly and more focused <input type="checkbox"/> Improve memory <input type="checkbox"/> Do better on tests in school <input type="checkbox"/> Stop using laxatives or stool softeners <input type="checkbox"/> Be free of pain <input type="checkbox"/> Have agreeable breath <input type="checkbox"/> Have agreeable body odor <input type="checkbox"/> Have strong teeth <input type="checkbox"/> Get less colds and flus <input type="checkbox"/> Get rid of your allergies <input type="checkbox"/> Increase your sex drive <input type="checkbox"/> Not be dependent on over-the-counter medications <input type="checkbox"/> Reduce the risk of inherited disease tendencies (e.g. cancer, heart disease)

Health History Continued Medical History

Please check all that apply:

<input type="checkbox"/> Arthritis <input type="checkbox"/> Allergies/hayfever <input type="checkbox"/> Asthma <input type="checkbox"/> Alcoholism <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Blood Pressure Problems <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Cholesterol, elevated <input type="checkbox"/> Circulatory problems <input type="checkbox"/> Colitis <input type="checkbox"/> Dental problems <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Disk Herniation <input type="checkbox"/> Diverticular disease <input type="checkbox"/> Drug addiction <input type="checkbox"/> Eating disorder <input type="checkbox"/> Epilepsy <input type="checkbox"/> Emphysema	<input type="checkbox"/> Eyes, ears, nose, throat problems <input type="checkbox"/> Environmental sensitivities <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Gastroesophageal Reflux Disease <input type="checkbox"/> Genetic Disorder <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hernia <input type="checkbox"/> Infection, Chronic <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Kidney or bladder disease <input type="checkbox"/> Learning disabilities <input type="checkbox"/> Liver or Gall Bladder Disease (stones) <input type="checkbox"/> Mental Illness <input type="checkbox"/> Mental retardation <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Neurological problems (Parkinson's, paralysis) <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid trouble <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> STD <input type="checkbox"/> Seasonal Affective Disorder (SAD) <input type="checkbox"/> Skin Problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcer <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> Varicose veins <input type="checkbox"/> Other: <hr/> Men's Medical <input type="checkbox"/> BPH (Benign Prostatic Hyperplasia) <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Decreased sex drive <input type="checkbox"/> Infertility <input type="checkbox"/> STD <input type="checkbox"/> Other: <hr/>	Women's Medical <input type="checkbox"/> Menstrual Irregularities <input type="checkbox"/> Infertility <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibrocystic breasts <input type="checkbox"/> Fibroids/ovarian cysts <input type="checkbox"/> PMS <input type="checkbox"/> Breast cancer <input type="checkbox"/> Pelvic inflammatory disease <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Decreased sex drive <input type="checkbox"/> STD <input type="checkbox"/> Other: _____ <hr/> Are you currently Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N Which trimester are you currently in? _____
--	--	---	--

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications/Reason	Allergies
_____	_____
_____	_____
_____	_____
_____	_____

NeuroMuscular Junction Wellness Center

Release and Indemnification

I understand that the massage therapist does not diagnose, or prescribe illness or disease nor perform spinal manipulation. I further understand that massage therapy is for the purpose of reduction of stress, muscular spasm or pain and improved circulation, energy and sense of well-being. All information shared by us, in or out of a session, in or out of the office is for educational purposes only.

All assessment information is a hypothesis, not diagnosis. Serious health conditions need to be discussed with the proper health practitioner or physician. I understand that a certain degree of discomfort may be expected due to muscle spasm and direct pressure is used to release the spasm. I will inform the therapist of any pain that I'm experiencing. I have filled this form completely to the best of my knowledge and ability.

I hereby authorize any physician to release any and all information, copies of all records to the NeuroMuscular Junction Wellness Center as deemed necessary for treatment. A copy of this authorization shall be considered as valid as the original.

Printed Name: _____ Date: _____

Signature: _____