

Client Name _____ Date _____
Date of Injury _____ ID#/DOB _____

How did you find out about Jessica's services? _____

Patient Information

Address _____
City _____ State _____ Zip _____
Phone: Hm _____
Wk _____ Cell _____
Email: _____
Employer _____
Work Address _____
City _____ State _____ Zip _____
Occupation _____
Emergency Contact _____
Phone: Hm _____
Wk _____ Cell _____

Primary Health Care Provider

Name _____
Address _____
City _____ State _____ Zip _____
Phone: _____ Fax: _____

If currently pregnant:

OB/GYN _____
Phone: _____ Fax: _____

List Daily Activities Limited by Condition.

Work _____
Home/Family _____
Sleep/Self-care _____
Social/Recreational _____

List Self-Care Routines.

Stress Level: (0-10, 1=low) 0 _____ 10
How do you reduce stress? _____
Pain Level: (0-10, 1=low) 0 _____ 10
How do you reduce pain? _____

List current medications (including Rx, OTC, pain relievers, herbal, homeopathic, and holistic remedies):

Have you ever received massage therapy before?

Frequency? _____
Last bodywork session received _____
What are your goals for receiving massage therapy and/or bodywork? _____

I give my massage therapist and/or bodyworker permission to consult with my health care providers regarding my health and treatment.
Comments _____
Initials _____ Date _____

Current Health Information

List Health Concerns. Check All That Apply.

Primary

mild moderate disabling
 constant intermittent
 symptoms ↑ w/ activity ↓ w/ activity
 getting worse getting better no change
Treatment Rec'd _____

Secondary

mild moderate disabling
 constant intermittent
 symptoms ↑ w/ activity ↓ w/ activity
 getting worse getting better no change
Treatment Rec'd _____

Additional

mild moderate disabling
 constant intermittent
 symptoms ↑ w/ activity ↓ w/ activity
 getting worse getting better no change
Treatment Rec'd _____

Health History

List and Explain. Include dates, treatment received.

Surgeries _____

Injuries/Falls _____

Major Illnesses _____

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Please check all current and previous conditions. If you have a specific medical condition or specific symptoms, massage and/or bodywork may be contraindicated. A referral from your primary care provider (and/or OB/GYN if currently pregnant) may be required prior to service being provided.

General

Current Past

- headaches
- pain
- sleep disturbances
- fatigue
- infections
- fever
- sinus
- other _____

Skin Conditions

- rashes
- athlete's foot/warts
- moles
- acne
- cosmetic surgery
- other _____

Muscles and Joints

- rheumatoid arthritis
- osteoarthritis
- osteoporosis
- scoliosis
- broken/fractured bones
- spinal problems
- disk problems
- lupus
- TMJ, jaw pain
- spasms, cramps
- sprains, strains
- tendonitis, bursitis
- stiff/swelling/painful joints
- weak or sore muscles
- neck/shoulder/arm pain
- low back/hip/leg pain
- other bone/jt disease
- fibromyalgia
- other _____

Nervous System

Current Past

- Parkinsons

- MS/MD
- epilepsy, seizures
- cerebral palsy
- spinal cord injury
- paralysis
- herpes/shingles
- CFS
- fatigue
- ulcers
- head injuries
- concussions
- dizziness, ringing in ears
- memory loss, confusion
- numbness, tingling
- sciatica, shooting pain
- chronic pain
- depression
- other _____

Respiratory, Cardiovascular

- heart disease
- blood clots
- stroke
- lymphadema
- high blood pressure
- low blood pressure
- irregular heart beat
- dizziness/fainting
- poor circulation
- swollen ankles
- varicose veins
- chest pain/short breath
- sinus problems
- asthma
- other _____

Allergies

- scents, oils, lotions
- detergents
- seasonal
- other _____

Digestive/Elimination System

Current Past

- nervous stomach
- diarrhea
- indigestion
- constipation
- diverticulitis
- IBS
- Crohns
- Colitis
- UTI
- bowel problems
- gas, bloating
- bladder/kidney/prostrate
- abdominal pain
- other _____

Endocrine System

- thyroid on medication
- diabetes on medication

Reproductive System

- pregnancy current Tri: _____ previous _____ attempting
- painful/emotional menses
- fibrotic cysts
- menopause, pre-menopause
- pelvic inflammatory disease
- endometriosis

Cancer/Tumors

- benign _____
- malignant _____

Habits (incl. quantity)

- tobacco _____
- alcohol _____
- drugs _____
- coffee, soda _____

| Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you wearing contacts? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you wearing dentures? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any contagious diseases or viruses? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you bruise easily? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have numbness or stabbing pains anywhere? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you very sensitive to touch or pressure in any area? _____ |

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Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

I understand that massage and bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage and bodywork professionals are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. Because massage and bodywork should not be performed under certain medical conditions, I affirm that I have reported all health conditions that I am aware of and answered all questions honestly. I agree to keep my practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I UNDERSTAND THAT ANY ILLICIT OR SEXUALLY SUGGESTIVE REMARKS OR ADVANCES MADE BY ME WILL RESULT IN **IMMEDIATE TERMINATION** OF THE SESSION AND I WILL BE LIABLE FOR PAYMENT OF THE SCHEDULED APPOINTMENT.

Consent for Care

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Client Signature: _____ Date _____

Practitioner Signature: _____ Date _____

I have read and received a copy of the Privacy Practices for Protected Health Information _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Jessica Shenefield, LMBT (NC License #8367) to administer massage, bodywork, or somatic therapy techniques to my child or dependent as deemed necessary or beneficial. This consent is valid for one year from the date originally signed or until notification of a change in guardianship—whichever occurs first.

Signature of Parent/Guardian: _____

Relationship: _____ Date: _____

Address: _____

Phone: _____ Email: _____