HEALTH HISTORY

Name _____ How did you find me?_____

Address _____City_____State_____Zip_____

Cell (or best #) _____ Email address: _____ Birth Date: _____

Emergency Contact Name & Phone # _____ **Relationship** _____

Please complete the following:

What are you seeking treatment for today?

_____

_____

Do you have any of the following today? Inflammation _____ Severe Pain _____ Headache _____ Cold or Flu _____

Open cuts, bruises, burns _____ Irritated skin rash _____

Are you Pregnant? _____ Trimester: _____ Due Date: _____ Is pregnancy "high risk"? _____

Surgeries? _____ Recent injuries_____

Check any of the following conditions you currently have or have experienced in the past:

In the last 72 hours:

Fever ____ Chills ____ Body Aches ____ Flu ____

Tested positive for: Epstein-barre ____ is it active? ____

Tuberculosis ____ is it active? ____

Osteoporosis ____ Diabetes ____ Arthritis ____

Hepatitis ____

HIV or AIDS ____

High Blood Pressure ____ Medication controlled ____

Varicose veins ____ (these are not spider veins)

Blood clots ____

Other Chronic Condition: ____ Diagnosis: _____

Heart problems ____ Diagnosis: _____

Skin conditions/allergies ____ Diagnosis: _____

Spinal problems ____ Diagnosis: _____

Cancer ____ Diagnosis: _____

Surgery to correct eye-tracking problems ____

Cerebral Aneurysm ____

Skull fracture ____ Date _____

Hydrocephalus ___ with shunt ____ without shunt ____

Herniated brainstem ____

Cerebrospinal fluid leaks ____

Other _____

Additional information about your circumstances you'd like me to know: _____

_____

_____

_____

Professional Services and Business Policies

Somatic or manual therapy refers to any number of techniques that involve improving your health by the specific application of the therapist's hands. Modalities for which I have received advanced training include CranioSacral Therapy, Reiki, Massage Therapy, and others. All of the modalities are designed to help you be as healthy as possible using the least invasive means possible.

Professional Fees

My hourly fee is $95. Payment is required at the time of the appointment, unless we agree otherwise. I do not file on insurance on your behalf, and I do not accept payment from your insurance. Should you need my services for other purposes including report writing or session records, it is my practice to charge the above fee on a prorated basis in 15 minute increments.

Confidentiality

In general, the confidentiality of all communications between a client and therapist is protected by law, and I can only release information about our work to others with your written permission. However there are some exceptions such as court order or for the sake of protection of self or others.

24-HOUR CANCELLATION POLICY

Payment is expected for appointments missed or cancelled within less than 24 hours advance notice except in cases of sudden illness or we both agree circumstances were beyond your control.

TREATMENT ACKNOWLEDGEMENT

I understand the following:

- Various modalities may be applied including, but not limited to: CranioSacral Therapy, Swedish Massage, Trigger Point Therapy, Polarity and Reiki.
- A Massage Therapist neither makes diagnosis nor treats illness or disease, or performs any spinal/skeletal manipulations and does not prescribe medications.
- I will be covered with sheets as appropriate for the treatment and only the areas that are treated will be uncovered during the treatment (This applies only to Massage Therapy as CranioSacral Therapy and Reiki don't require disrobing).
- If at any time during the session I feel uncomfortable, I may request the therapist to stop the treatment immediately.
- All prepaid services are non-refundable.

An individual who wishes to file a complaint against a massage therapist, a massage therapy school, a massage therapy instructor, or a massage therapy establishment may write to: Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. *This number is for complaints only.*

By signing below, you agree that you have read and understand the information stated in this document.

Printed Name _____

Client Signature_____Date: _____

Therapist Signature _____Date: _____