

## HEALTH HISTORY

Name \_\_\_\_\_ How did you find me? \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell (or best #) \_\_\_\_\_ Email address: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Emergency Contact Name & Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

What are you seeking treatment for today?

\_\_\_\_\_

\_\_\_\_\_

How are these issues affecting your daily life?

\_\_\_\_\_

\_\_\_\_\_

Please list any medications you take:

\_\_\_\_\_

\_\_\_\_\_

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

<input type="checkbox"/> Skin conditions _____	<input type="checkbox"/> Headaches/Migraines _____
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Dizziness, ringing in ears _____
<input type="checkbox"/> Varicose veins (these are not spider veins) _____	<input type="checkbox"/> Digestive conditions _____
<input type="checkbox"/> Osteoporosis _____	<input type="checkbox"/> Endocrine/thyroid conditions _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Spinal problems _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> Depression, anxiety _____
<input type="checkbox"/> HIV or AIDS _____	<input type="checkbox"/> Surgery to correct eye-tracking problems _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Cerebral Aneurysm _____
<input type="checkbox"/> High Blood Pressure _____ Medication controlled? _____	<input type="checkbox"/> Skull fracture Date _____
<input type="checkbox"/> Blood clots _____	<input type="checkbox"/> Hydrocephalus _____ with shunt _____ without shunt
<input type="checkbox"/> Heart problems _____	<input type="checkbox"/> Herniated brainstem _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Cerebrospinal fluid leaks _____
<input type="checkbox"/> Epilepsy/Seizures _____	Other _____

Do you have any of the following today?  Severe Pain  Headache  Cold or Flu  Open cuts, bruises, burns

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

Surgeries? \_\_\_\_\_ Recent injuries \_\_\_\_\_

**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, SomatoEmotional Release, Reiki, Massage Therapy, Reflexology, 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 \$100. 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 emergencies beyond your control. The appointment may be taken off of a package or charged individually.**

### **TREATMENT ACKNOWLEDGEMENT**

I understand the following:

**- I have read and agree to the 24-Hour Cancellation Policy.**

- 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: \_\_\_\_\_