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?

_____

_____

What is your goal for your health & wellbeing?

_____

On a scale from 1-10 (10 being optimal) how do you rate the health of your:

Diet _____Exercise _____Sleep_____Breathing_____Mental Stress_____Physical Stress_____

Please list any medications you take:

_____

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

___ Skin conditions _____

___ Allergies _____

___ Osteoporosis

___ Arthritis

___ Diabetes

___ Hepatitis

___ HIV or AIDS

___ Asthma

___ High Blood Pressure ___Medication controlled?

___ Blood clots

___ Heart problems _____

___ Stroke

___ Epilepsy/Seizures

___ Headaches/Migrainses

___ Dizziness, ringing in ears

___ Digestive conditions _____

___ Endocrine/thyroid conditions _____

___ Spinal problems _____

___ Cancer _____

___ Depression, anxiety _____

___ Surgery to correct eye-tracking problems

___ Cerebral Aneurysm

___ Skull fracture Date _____

___ Hydrocephalus ___with shunt ___without shunt

___ Herniated brainstem

___ Cerebrospinal fluid leaks

Other _____

Other Chronic Condition: _____

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 we both agree are 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:_____