

BODY N SOUL MASSAGE CONFIDENTIAL CLIENT INFORMATION & HEALTH HISTORY

First Name: _____ M.I. ____ Last Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____ Marital Status: _____

Email: _____ Date of Birth: _____

Referred By: _____ Height: _____ Weight: _____ Anniversary: _____

Occupation: _____ Employer: _____

Is this your first professional massage? _____ If no, how frequently do you get a massage? _____

What types of massage/bodywork have you had? _____

What do you hope to accomplish from today's massage? _____

Do you exercise or participate in sports? _____ If yes, what types? _____

Describe any surgeries, hospitalizations, accidents or injuries you have had (including date of occurrence) :

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel that you have recovered from these events? _____ If no, please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____

Describe what activities cause this pain and/or make it worse? _____

Are you receiving any other type of medical treatment? _____ Please explain: _____

Are you currently under the care of a physician? _____ Whom? _____

Please list reason: _____

Do you receive chiropractic care? _____ If yes, with whom and how often? _____

Are there any other concerns you wish to discuss today? _____ If yes, please describe: _____

PLEASE TURN PAGE OVER & CONTINUE ON REVERSE

Health History (Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years)

MUSCULOSKELETAL

- Fibromyalgia
- Spasms/Cramps
- Sprains/Strains
- Osteoporosis
- Postural Deviations
- Gout in _____
- Arthritis
- Bursitis
- Carpal Tunnel Syndrome
- Sciatica
- Thoracic Outlet Syndrome
- Plantar Fasciitis
- Cysts/Lipomas
- TMJ
- Chronic Headaches
- Tendonitis
- Whiplash Syndrome
- Chronic pain in:
 - Neck
 - Low Back
 - Mid Back
 - Upper Back
 - Hip
 - Arm
 - Leg
 - Shoulder
 - Wrist/Hand
- On computer more than 2 hrs/day: _____ hrs

RESPIRATORY

- Pneumonia
- Asthma
- Breathing Problems
- Sinusitis
- Other: _____

DIGESTIVE

- Ulcers
- Colitis
- IBS
- Chron's Disease
- Diarrhea
- Gallstones
- Gas/Bloating
- Chronic Indigestion

CIRCULATORY

- Heart Palpitations
- Heart Condition: _____
- Mitral Valve Prolapse
- Anemia
- Hemophilia
- High Blood Pressure
- Low Blood Pressure
- Peripheral Artery Disease
- Raynaud's Disease
- Varicose Veins
- Blood Clots/Phlebitis

SKIN

- Fungal Infections
- Athlete's Foot
- Rashes
- Eczema/Dermatitis
- Psoriasis
- Easily Irritated Skin
- Other: _____

NERVOUS SYSTEM

- Dizziness
- ALS
- Multiple Sclerosis
- Parkinson's Disease
- Bell's Palsy
- Neuritis
- Spinal Cord Injury
- Trigeminal Neuralgia
- Seizure Disorders
- Numbness/Tingling/Twitching
- Other: _____

OTHER

- Hypothyroidism
- Diabetes
- Pregnancy
- Cancer _____
- Kidney Disease
- Hepatitis
- HIV/AIDS
- Lupus
- Cystitis
- Chronic Fatigue
- Edema

- Bladder Infections
- High Stress
- Grieving
- Anxiety/Panic Attacks
- Bipolar Syndrome
- PMS/Menopause Difficulties
- Poor Sleep/Insomnia
- Allergies Affecting
 - Facial Skin
 - Body Skin
 - Nose/Sinuses
 - Stomach/Gut
 - Eyes
- Postoperative: _____
- Other: _____

NOTE: If at any time you feel discomfort, please tell me. The pressure can always be adjusted for your comfort. This is your massage session, and I won't know unless you tell me. I understand that massage & bodywork should not be construed as a substitute for medical examination, diagnosis or treatment. Because massage & bodywork should not be performed under certain circumstances, I affirm I have stated all my known medical conditions. I agree to keep the therapist updated if changes occur in my medical profile.

Signature

Date

CONSENT TO TREATMENT OF MINOR: I authorize massage be performed on my above named child.

Signature of parent/guardian

Body N Soul Massage

Deborah Shahadey
634 E. Davis Drive, Terre Haute, IN 47802
(812) 230-0697

Please understand that your time commitment begins at the moment you reserve a massage. In order to make it fair to everyone, please consider your schedule carefully and don't commit to a time that you feel may be questionable. There are times when a cancellation is, of course, necessary. Please give advanced notice whenever possible. Cancellations and/or rescheduling must be made no less than 4 hours (*medical emergencies excluded*) prior to the session or a \$25 cancellation fee will be billed. On the other hand, if I need to cancel or reschedule your appointment without 4 hours notice, **you will receive a \$25 credit for your next appointment.**

At one time or another you may be running late. This may sometimes be due to circumstances you can't control. However, if this happens, our session will still end at the appointed time. This is due to the fact that it would not be fair to the client who has an appointment behind you and those that follow throughout the whole day.

I understand that massage therapists do not diagnose illness or disease, nor prescribe medical treatment, spinal manipulations or treat specific conditions. I further understand that massage therapy is not a substitute for medical attention or examination. I take full responsibility for alerting my massage therapist to any physical, mental or emotional changes that occur with my health. I also understand that massage/bodywork is for the purpose of stress reduction, relaxing tension and general relaxation which helps to improve nerve and blood supply and energy flow.

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.

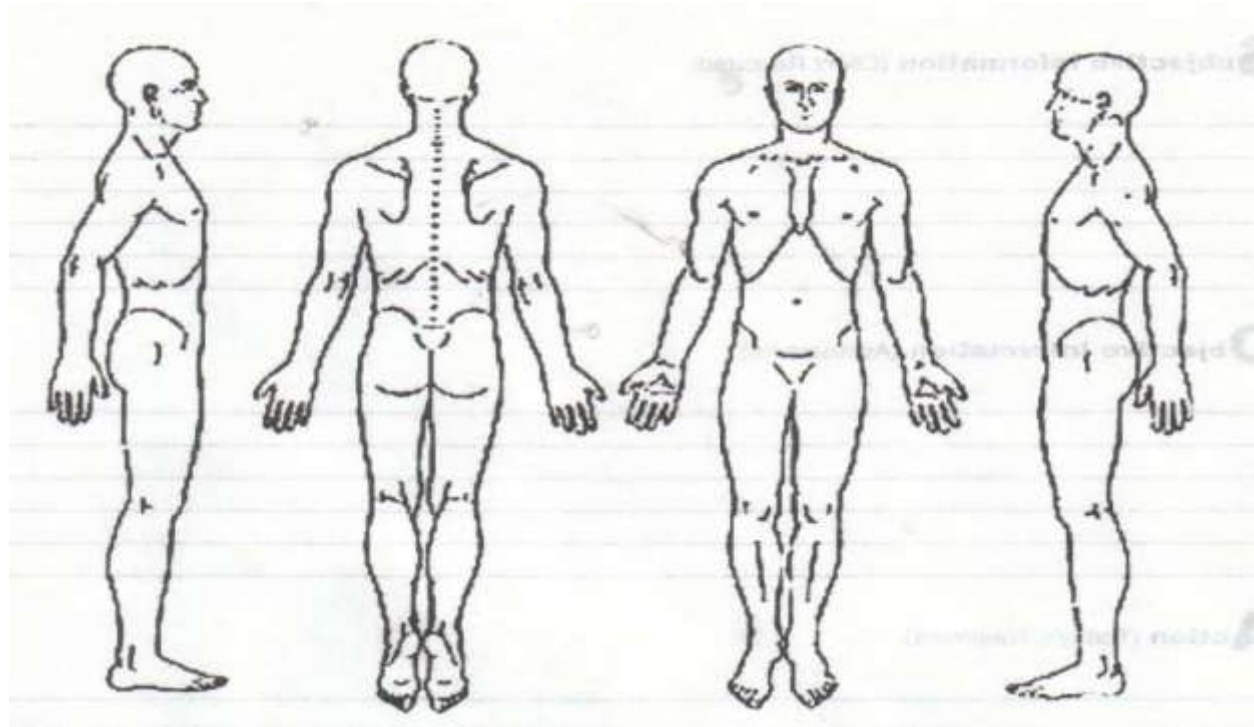
I have read, understand, and agree to the above policy.

Signature: _____

Date: _____

NAME: _____ DATE: _____

On the following pictures, please **circle the problem areas** you are having **today** and the **pain sensation**: ex: Pain, tightness, knots, tingling, stiffness, sore, numbness, etc.



- What **TYPE OF PRESSURE** would you like **TODAY**?

Swedish, Aromatherapy, Neck & Shoulders, Senior, Pregnancy or Hot Stone:

Very light Light Light to medium Medium

Deep Tissue:

Medium to Deep Deep Very Deep Can't go hard enough

- Any areas you would **NOT** like massaged? _____

- **Currently**, are you experiencing any of the following conditions?

Cold or flu Fever Inflammation
 Infection Open Wounds/Sores Contagious Disease

- Comments: _____

Client Signature: _____ Date: _____

STOP

SOAP Notes (Filled out by massage therapist ONLY)

Client name: _____ Client claim # _____

Treatment Date: _____ DOI _____

SUBJECTIVE INFORMATION (Client reported)

OBJECTIVE INFORMATION (Objective Assessment)

ACTION (Application) What kinds of treatment were used? Changes occur?

PLAN of treatment/Progress

Therapist's Signature: _____ **Date:** _____