TRINITY MASSAGE

Client History Form

CLIENT INFORMATION

NAME: _____ **DATE of BIRTH:** _____

ADDRESS: _____
Street Apartment/Unit # City, Town, Zip

PHONE (home): _____ **PHONE (cell or work):** _____

EMAIL: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

PRIMARY CARE PROVIDER INFORMATION

NAME: _____ **OFFICE / INSTITUTIONNAME:** _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

Do you give your permission to have your PCP contacted if necessary? **YES** ____ **NO** ____

Do you have any chronic issues or injuries which are currently being treated?

_____

_____

_____

MEDICATIONS **None**

Name	For	Last Taken	Additional Information

Please check all current and previous conditions. Where more than one condition is given, please circle which one(s) specifically.

FOR THERAPIST'S USE:

MUSCULO-SKELETAL

broken / fractured bones _____

arthritis / tendonitis / bursitis _____

spasms / cramps _____

sprains / strains _____

bone / joint disease _____

spinal conditions _____

other: _____

SKIN

rashes / athlete's foot _____

eczema / psoriasis _____

other: _____

DIGESTIVE

bladder / kidney dysfunction _____

colitis / Crohn's disease _____

diverticulitis / IBS _____

ulcer(s) _____

other: _____

CIRCULATORY / RESPIRATORY

asthma _____

varicose veins _____

stroke / blood clots _____

high / low blood pressure _____

heart condition(s) _____

swelling / inflammation _____

other: _____

NERVOUS SYSTEM

numbness / tingling _____

head injuries / concussions _____

herpes / shingles _____

sciatica _____

paralysis _____

other: _____

ADDITIONAL CONDITIONS

diabetes: type I / type II _____

pregnancy _____

headaches _____

cancer _____

tumor(s): benign / malignant _____

allergies _____

other: _____

_____

_____

SURGERIES: Please provide the name, location and date of surgery

_____

_____

_____

_____

Have you ever had any major injuries, accidents (e.g. car), or chronic pain issues? **N** **Y**

Injury / Accident/ Pain Issue	Location	When	Cause / Treatment

Is there anything else that you would like the therapist to know?

Consent to Treatment and Statement of Understanding

I, _____, the client, understand that massage does not substitute for medical treatment or medications, and that it is recommended that I work with my primary care provider for any conditions I may have. I am aware that the massage therapist does not diagnose any illness, disease, or conditions.

I have informed the massage therapist of all known physical conditions, medical conditions, and prescriptions. I understand that I am responsible for updating the therapist on any changes. It is my choice to receive manual therapy, and I give my consent to receive treatment.

I understand and agree that I am ultimately responsible for the cost of any and all professional services rendered.

Minor children are required to have a parent or legal guardian present at the time of their appointment or no service will be provided and the appointment will be rescheduled. In the case of divorced or separated parents, the parent who brings the child into the office is responsible for any charges.

I authorize Whole Life Health Care, P.A., and its physicians, health care practitioners, employees and the subcontractors in collaboration with Whole Life Health Care, P.A., to have access to my medical records for the purpose of medical treatment/services within the Whole Life Health Care, P.A. facility.

☐ Please check this box if you do not authorize your information to be shared with Whole Life Health Care, P.A.

A notice of 24 hours is required when canceling appointments. If the cancellation is less than 24 hours, you will be charged a fee worth 50% of the session cost which will be due within 10 business days from the date of the original appointment.

My signature below acknowledges the above statements as fully read and understood.

Signature: _____ **Date:** _____

Signature of parent/guardian: _____ **Date:** _____
(if client is under 18 years of age)