



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:** \_\_\_\_\_  
*(if client is under 18 years of age)*

**Date:** \_\_\_\_\_