

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Angelical Touch

Angel Rivera, Licensed Massage and Bodywork Therapist, LMBT, NC #7517
The Chiropractic Wellness Studio, Inc., 148 Morrisville Square Way, Morrisville, NC 27560
Cellular phone: 919-744-8081

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip _____

Phone (home): _____ (work) _____ (cellular) _____

e-mail: _____

Occupation: _____ Referred by: _____

Is this your first professional massage? _____

What kind of pressure do you prefer? ___ Light ___ Medium ___ Firm

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

Are you aware of any tension holding spots in your body? _____ If yes, location(s)

The pubic area, the genitals, the gluteal cleft and the breasts (in females), are covered and are not massaged.

Are there any other areas of your body that you **DO NOT** want massaged? (Scalp) (Face) (Neck) (Shoulders) (Arms) (Hands) (Upper back) (Upper chest) (Mid back) (Abdomen) (Lower back) (Glutes) (Inside of thighs) (Legs) (Feet)

If you are female, breasts may be treated after we discuss your objectives and appropriate techniques and you complete a separate consent form. Would you like information about recovery from surgery, scar improvement or holistic breast massage? ___ No ___ Yes, which? _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

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

Please explain: _____

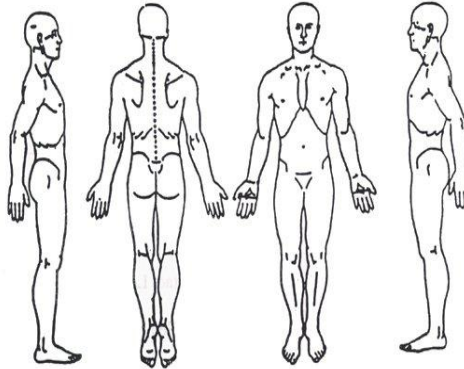
Describe what activities cause this pain and/or make it worse: _____

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

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

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

On the figure below, please shade in any areas where there is pain or stiffness



If you answer "yes" to any of the following questions, please explain as clearly as possible.

- Yes No Do you frequently suffer from stress?
- Yes No Do you experience frequent headaches?
- Yes No Are you wearing contact lenses?
- Yes No Are you wearing dentures?
- Yes No Do you suffer from joint swelling?
- Yes No Do you have osteoporosis?
- Yes No Do you have high blood pressure?
- Yes No Do you have diabetes?
- Yes No Do you have any allergies? Explain: _____
- Yes No Do you have a diagnostic of cancer? Explain: _____
- Yes No Do you have numbness or stabbing pains? Explain: _____
- Yes No Are you sensitive to touch or pressure in any area? Explain: _____
- Yes No Do you have tension or soreness in a specific area? Explain: _____
- Yes No Other medical condition, or are you taking any medications I should know about? _____

- Yes No Do you suffer from chronic back pain?
- Yes No Do you suffer from arthritis?
- Yes No Do you bruise easily?
- Yes No Do you suffer from epilepsy or seizures?
- Yes No Do you have varicose veins?
- Yes No Do you have cardiac or circulatory problems?
- If yes, are you taking medication? Yes No
- If yes, are you insulin dependent? Yes No

Women: Yes No Are you pregnant?

Comments

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Angel Rivera to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____

Name of Parent or Guardian: _____