Innate Wisdom
Wellness From the Inside

Client Health History

- Your answers to the following questions will be kept confidential. They will be seen only by the therapist(s) and are requested so that better care may be provided to you.
- Payment is due at the time service is rendered.
- 24-hour notice is expected for cancellations or fees will be applied.
- Any sexual advances, innuendo, or gesturing will result in immediate session termination with the full session rate charged.

Today's Date: _____ Email Address: _____

Client Name: _____

Address: _____

City:_____ State:_____ Zip: _____

Daytime Telephone:_____ Evening Telephone: _____

Age _____ DOB:_____ Gender Identity:_____

Currently Pregnant? _____ Contact Lenses? _____ Hearing Aid? _____

What is the nature/type of work you do regularly? _____

What do you do for movement? _____

What do you do for fun/hobbies? _____

How did you learn about us? (Yellow Pages, Friend, Dr., P.T., D.C., Etc.):_____

Have you received massage before?_____

If you've had massage before, what types of strokes or techniques did you most enjoy?_____

_____

Reason(s) for coming in for Massage:
☐ Relaxation/Stress Reduction ☐ Increase Body Awareness ☐ Pain ☐ Feels Great ☐ Integration of Mind-Body-Emotions ☐Part of Recovery ☐ Injury Date of Accident: _____
☐ Other Reason: _____

Specific areas or issues you want addressed during the session:
_____

Any major physical traumas your body has experienced (accident, fall, surgery, etc)?_____

Allergies or Scent Sensitivities? _____

Drugs/Medicine taken in the last 2 weeks (Prescription/OTC/Recreational): _____

How are you feeling in your body today? _____

Please describe any symptoms you are experiencing (location, intensity, frequency, duration and onset):_____

_____

_____

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Which activities relieve your symptoms?

_____

_____

Which activities aggravate your symptoms?

_____

_____

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/fractured bones
- ☐ Strains/sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain/TMJ Dysfunction
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or joint disease
- ☐ Other: _____

Circulatory and Respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Other: _____

Skin

- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other: _____

Digestive

- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Adaptive aids
- ☐ Other: _____

Nervous System

- ☐ Numbness/tingling
- ☐ Twitching of face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's disease
- ☐ Spinal cord injury
- ☐ Other: _____

Reproductive System

- ☐ Pregnancy:
  - ☐ Current
  - ☐ Previous
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Prostate problems
- ☐ Other: _____

Other

- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Drug use_____
- ☐ Alcohol use _____
- ☐ Nicotine use _____
- ☐ Caffeine use _____
- ☐ OTC pain relievers _____
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Burning upon urination
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ COVID-19
- ☐ Infectious disease (please list)_____ _____
- ☐ Other congenital or acquired disabilities (please list) _____
- ☐ Surgeries _____
- ☐ Other: _____

Please list any additional comments regarding your health and well-being:

_____

_____

_____

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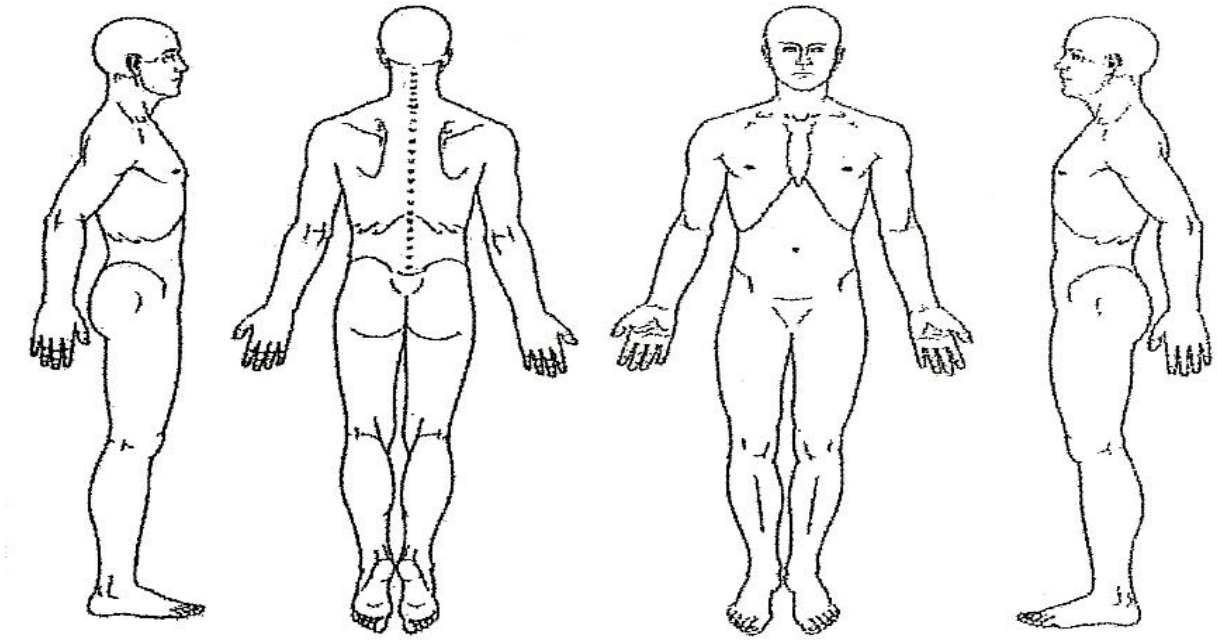
On the images below, please circle specific areas where you are **currently** experiencing pain, discomfort, lack of strength or mobility.



(Right Side) (Posterior) (Anterior) (Left Side)

(Optional)

Any major emotional traumas you have experienced (divorce, violence, etc)? _____

Are you a survivor of: ☐ physical abuse ☐ sexual abuse ☐ PTSD ☐ Other:_____

Are these issues current for you? _____

In this regard, is there anything specific you would like me to keep in mind during your session (e.g. don't stand where I can't see you, don't touch my neck, etc)_____

Health Care Providers from whom you are currently receiving care:

Practioner's Name	Field of Practice	City/State	Phone

Is there anything else the therapist should know?

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status. I understand that the services provided are not a replacement for medical or psychological care and that any information given to me is not prescriptive or diagnostic in nature and is for educational purposes only. I also give my permission for the LMT(s) with whom I work to discuss information pertinent to my condition(s) and treatment, with my other health care providers.

Client Signature:_____ Date: _____

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