tammy.tomich@yahoo.com

Client Contact Information

Client Name:_____ Date:_____

Date Of Birth:_____ Gender:_____

Address:_____

Phone:_____ Email:_____

Referred by:_____

Emergency contact:_____ Phone:_____

Physician/Health-care Provider name:_____ Phone:_____

Do you have a physician referral/prescription? Yes No

Are you seeking insurance reimbursement? Yes No

If yes, would you like invoicing? Yes No

Myofascial Release Information /Subtle Energy /Reiki / Therapeutic Touch

Have you ever received MFR/ Energy Therapy before? Yes No

How recently?_____

What types of massage/bodywork have you received?_____

What are your goal/expected outcomes?_____

_____

How do you feel today? _____

List and provide your current symptoms/issues (stress, pain, stiffness, numbness/ tingling, swelling, etc): _____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No

Please explain: _____

_____

List the medications and/or supplements you currently take:

_____

_____

Are you wearing hearing device? Yes No

Are you wearing contacts? Yes No

Are you wearing dentures? Yes No

Are you wearing a hairpiece? Yes No

Are you pregnant? Yes No

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

Blood clots, infections, congestive heart failure, contagious diseases, cited edema

Please answer honestly, as massage may not ice indicated for the above conditions.

Please indicate conditions you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain_____

Current Past Muscle or joint stiffness_____

Current Past Numbness or tingling_____

Current Past Swelling _____

Current Past Bruise easily _____

Current Past Sensitive to touch/pressure_____

Current Past High/low blood pressure_____

Current Past Stroke, heart attack_____

Current Past Varicose veins_____

Current Past Shortness of breath, asthma_____

Current Past Cancer_____

Current Past Neurological(e.g. MS, Parkinson's, chronic pain)_____

Current Past Epilepsy, seizures_____

Current Past Headaches, Migraines_____

Current Past Dizziness, ringing in the ears_____

Current Past Digestive conditions (e.g. Crohn's, IBS)_____

Current Past Gas, bloating, constipation_____

Current Past Kidney disease, infection_____

Current Past Arthritis (rheumatoid, osteoarthritis)_____

Current Past Osteoporosis, degenerative spine/disk_____

Current Past Scoliosis_____

Current Past Broken bones_____

Current Past Allergies_____

Current Past Diabetes_____

Current Past Endocrine/thyroid conditions_____

Current Past Depression, anxiety_____

Current Past Memory Loss, confusion, easily overwhelmed_____

Comments:

_____

_____

Consent for Treatment

If I experience any pain our discomfort during this session, I will immediately inform the practitioner so that the techniques may be adjusted to my level of comfort. I further understand that Myofascial Release/ Energy Therapies should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical aliment of which I am aware. I understand that MFR/ Energy practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session is given should be construed as such. Because MFR/ Energy Therapies should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answers all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that as 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. Understanding all of this, I give my consent to receive care.

Client Signature:_____ **Date:**_____

Parent or Guardian Signature (in case of a minor):_____

Date:_____