

CLIENT INFORMATION AND CONSENT FORM

Date _____

Name _____

Home Phone _____ Work/Cell Phone _____

Date of Birth _____ Referred by _____

Occupation _____ Email Address _____

Emergency Contact _____ Phone _____

Have you received bodywork before? Y N If yes, how long since last session? _____

Do you have allergies to any oils, lotions or creams? Y N If so, what? _____

Please circle the degree of stress or fatigue to the following life areas:

Work 1 2 3 4 5 6 7 8 9 10

Mental 1 2 3 4 5 6 7 8 9 10

Physical 1 2 3 4 5 6 7 8 9 10

Social 1 2 3 4 5 6 7 8 9 10

Spiritual 1 2 3 4 5 6 7 8 9 10

Lifestyle 1 2 3 4 5 6 7 8 9 10

Symptoms affect sleep? Y N

Receiving medical treatment? Y N

Pregnant? Y N

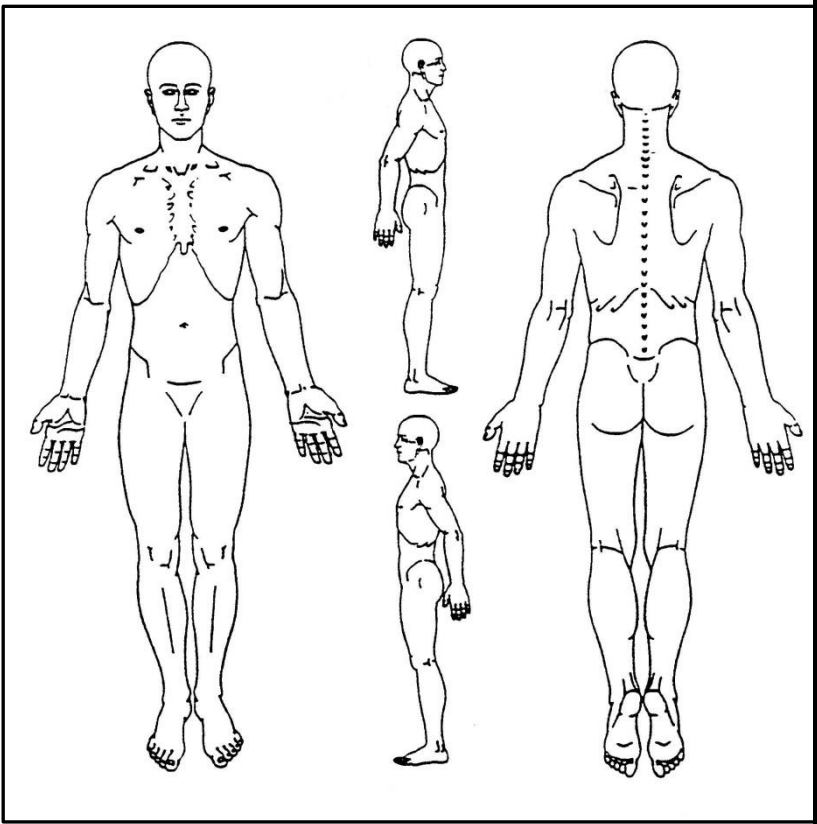
Wearing contacts? Y N

Medications? Y N Please list below:

Your Goals for today's session: 1) _____

2) _____ 3) _____

Long Term Goals: 1) _____ 2) _____



Systems Review: Please indicate if you have or have had conditions affecting the following systems of the body. Circle or give missing details, such as hx of cancer in any system.

Skin (contagious, wound/burns, rashes, warts, infections, easy bruising)

Skeletal/joint (osteoporosis, arthritis, scoliosis, spinal/disc issues, fracture, bursitis, replacements)

Circulatory (blood clots, stroke, heart problems, high/low blood pressure, varicose veins, poor circulation) _____

Endocrine (diabetes, hyper/hypo thyroid, peri menopause, adrenal) _____

Respiratory (allergies, asthma, emphysema, bronchitis, chronic cough, deviated septum, apnea)

Digestive (abdominal pain, bowel discomfort, gastric reflux, food sensitivities, bloating) _____

Urinary (bladder issues, kidney dysfunction, kidney stones, frequent UTI's) _____

Reproductive (infertility, ectopic, hysterectomy, fibroids, miscarriage) _____

Neurological (migraines, epilepsy or narcolepsy, hx of trauma, RLS, cataplexy) _____

Please list any major illnesses, surgeries or accidents that you have had. Include childhood.

Date _____ Details _____

Date _____ Details _____

Date _____ Details _____

I understand that massage and craniosacral is for enhancement of health and well-being and is not a substitute for medical treatment and diagnosis and that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I have stated all my known medical conditions and history and understand that it is my responsibility to keep Carrie Coy, LMT, CST, informed of any changes in my health and of any medications I may take in the future.

Signature _____

Date _____