Balance & Restore
WELLNESS

Health Questionnaire for all Treatments

Massage and body work increases circulation of lymph, blood, and oxygen, and research shows that it reduces stress, tension, and pain. S.I. can aid in relaxation, increased energy, and better sleep.

However, any body work may affect a pre-existing condition, and some conditions may be contraindicated for certain types of body work. Therefore, this form must be completed prior to receiving treatment.

All information will be kept confidential.

Please print clearly.

Contact Information

Name (last, first):

D.O. B. / / Occupation:

Home Address:

City: State: Post Code

Mobile:

Email:

Home Phone

Business Phone:

Best contact option is (circle): Mobile # Home # Business # Email

Emergency Contact Name:

Emergency Contact Phone:

How did you hear about us (circle)?:

Referral: Website Internet Search Walk-in

Medical Information

Circle any current conditions:

Skin

Boils
Fungal infections
Herpes Simplex
Warts/moles
Eczema
Psoriasis
Skin cancer
Skin allergies
Rashes
Burns
Severe Sunburn
Scars
Bruise easily
Other:

Circulatory/Lymph/ Endocrine System

Anemia
Infection
Heart disease/condition
High blood pressure
Low blood pressure
Varicose Veins
Diabetes
Clotting disorders
Edema
Lymphedema
Hodgkin's disease
AIDS, HIV
Chronic Fatigue Syndrome
Lupus
Cold/flu/fever
Hypo/hyperthyroidism
Leukemia/lymphoma
Bleeding (not including menstruation)
Other:

Respiratory System

Sinus problems
Tuberculosis
Asthma
Emphysema
Other:

Musculo-skeletal System

Fibromyalgia
Rheumatoid arthritis
Osteoarthritis
TMJ dysfunction
Strains, sprains, tendonitis
Bursitis
Carpal tunnel syndrome
Thoracic outlet syndrome
Cramping, spasms, soreness
Broken or fractured bones
Osteoporosis /Osteopenia
Loss of motion or mobility
Difficulty with prolongedstanding
Unable to comfortably lie on front, back or sides
Other:

Digestive/Urinary System

Cirrhosis
Ulcer
Gallstones
Hepatitis
Irritable Bowel Syndrome
Kidney stones
Reflux esophagitis
Bladder infection
Eating disorder
Other:

Nervous System
Multiple Sclerosis
Spinal cord injury
Brain injury
Numbness/tingling
Headaches
Stroke
Seizure disorder
Reduced sensation
Other:

Reproductive System

Breast cancer
Ovarian cysts
Painful menstruation
Pregnant
Prostate cancer
Pelvic Inflammatory Disease
Other:

Hearing impaired
Visually impaired
Insomnia
Cancer (other than specified above, including undiagnosed lumps)
Alcoholism/substance abuse
Caffeine or nicotine user
Physical abuse
Psychological condition
Using over the counter medication
Accidents:

Surgery other than specified above:

Other:

Please explain any circled items:

Are you presently under the care of a physician/physical therapist/chiropractor, Osteopath? Yes No

If yes, please explain:

Do you have your physician's permission to receive this treatment? Yes No Not Necessary

Please list any medications and their purposes:

Do you regularly exercise? Yes No

If yes, what activity and how often?

Body work Information

When was your last Body Work session?

Was there any part of the service you were NOT pleased with?

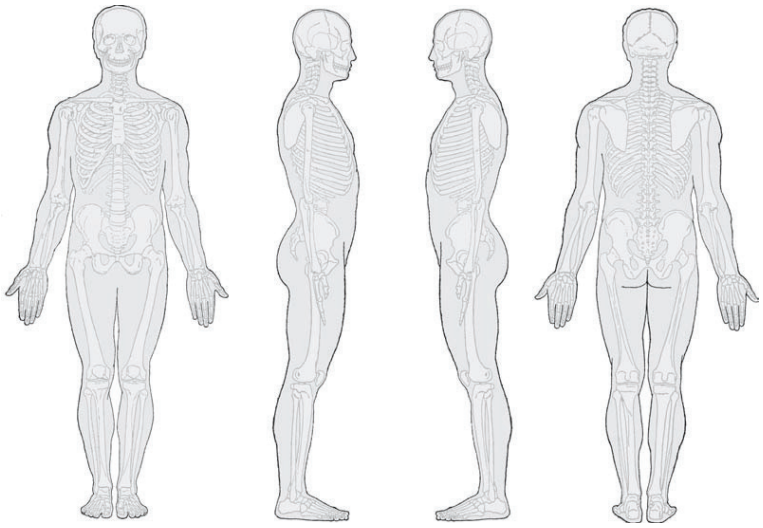
Was there any part of the you especially liked?

The level of stress you feel today is: Low Medium High

How has stress affected your health (e.g., anxiety, insomnia, moodiness, muscle tension, etc.)?

Is there a particular area of the body where you are experiencing tension, stiffness, or pain? Yes No

If yes, please identify below:



How often do you experience symptoms? Constantly Frequently Occasionally Intermittently

Describe your symptoms? Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? Getting better Staying the same Getting worse

When is it worst? Morning Evening Sitting Walking Driving Standing

Have you seen a doctor for these symptoms? Yes No

Do you have any particular goals in mind for this Anatomy Trains Structural Integration session?

Policies

1) I understand that draping will be used during the session. As much as possible only the area being worked will be uncovered.

Initials: Date:

2) I understand that at least 24 hours of notice is required for cancellation of an appointment, and that a fee of 100% of the cost of the scheduled service will be charged to when this courtesy is not provided.

Initials: Date:

3) I understand that I am to arrive 10 min before my scheduled appointment. This prevents any stress in scheduling to me or the therapist, and allows time to use the facilities, turn off my cell phone, and to relax.

Initials: Date:

4) I understand that I am to notify my ATSI therapist of any changes in my well-being and health care.

Initials: Date:

5) I understand that if I experience any pain or discomfort during this session, I will immediately inform the therapist so that pressure and/or strokes may be adjusted to my comfort level.

Initials: Date:

6) I understand that during the session if any sexual advances verbally or physically are made, the therapist has the right to end the treatment at that time and I will pay full price for the session.

Initials: Date:

7) I understand that ATSI is not a substitute for medical examination, diagnosis, or treatment, though it may be a complementary therapy. I understand that ATSI can increase soreness and/or pain if I do not follow proper precautions following the treatmetnt.

Initials: Date:

I, _____, affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there is no liability on the therapist's part should I fail to do so. In the event that I become injured either directly or indirectly as a result, in whole or in part of the aforesaid treatmetnt. I HEREBY HOLD HARMLESS AND INDEMNIFY the therapist and her/his principals and agents from all claims and liability whatsoever.

Signature: Date:

Practioner's Notes

This section is to be completed by the practioner:

Date: Time: Length of Session:

Observations:

Date: Time: Length of Session:

Observations:

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Observations:

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Observations:

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Observations:

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