Heal in Hands
Heal Through Massage

CLIENT PROFILE QUESTIONNAIRE

NAME: ________________________ DATE OF BIRTH:_____/_____/______ OCCUPATION: ________________________

ADDRESS : ____ MOBILE NUMBER: ____________________

____ HOME PHONE:_______________________

E-MAIL ADDRESS: ____ WORK PHONE: _______________________

EMERGENCY CONTACT : ____ NUMBER: ____________________________

REASON FOR APPOINTMENT: ____

WHEN & HOW DID THE ISSUE START: ____

IS THIS: **NEW** ☐ **RECURRING** ☐ **ONGOING** ☐ **IMPROVING** ☐ **NO CHANGE** ☐ **GETTING WORSE** ☐

DOES ANYTHING HELP IMROVE IT :____

DOES ANYTHING AGGREVATE IT :____

HAS IT BEEN TREATED BEFORE : ____

DOCTORS NAME & PRACTICE : ____

ARE YOU UNDER ANY Dr TREATMENT : ____

ADVISE OF ANY MEDICATION TAKEN & REASON : ____

DO YOU HAVE CHILDREN: _____ ARE THEY WELL: _____ ARE YOU PREGNANT: _____ DUE DATE : ______________

PLEASE CHECK AND PUT A CROSS (X) IN ALL BOXES THAT APPLY TO YOU:

☐	ALLERGIES	☐	DIFFICULTY SWALLLOWING	☐	NUMBNESS
☐	ANXIETY	☐	DIGESTIVE COMPLAINTS	☐	OPERATIONS
☐	ARTHIRITIS	☐	DIZZINESS	☐	OSTEOPEROSIS
☐	ASTHMA	☐	EARS - GLUE EAR	☐	PAIN THAT RADIATES
☐	BACK PAIN	☐	EARS - RINGING	☐	PERIOD PROBLEMS
☐	BEREAVEMENT	☐	EPILEPSY	☐	PINS AND NEEDLES
☐	BLOOD CLOTS	☐	FEET - COLD OR NUMB	☐	PREGNANCY
☐	BLOOD PRESSURE - HIGH	☐	HANDS - COLD OR NUMB	☐	SENSITIVE TO PRESSURE
☐	BLOOD PRESSURE - LOW	☐	HEADACHES	☐	SENSITIVE TO TOUCH
☐	BOTOX / FILLERS	☐	HEART PROBLEMS	☐	SIGHT PROBLEMS
☐	BREATHING PROBLEMS	☐	HYPERMOBILITY	☐	SINUSITIS
☐	BROKEN BONES	☐	IMPLANTS / STENTS	☐	SKIN PROBLEMS
☐	CANCER	☐	INDIGESTION	☐	SLEEP PROBLEMS
☐	CHEST PAIN	☐	INFECTIONS	☐	SCIATICA
☐	CHOLESTEROL	☐	JOINT PROBLEMS	☐	TATTOOS
☐	DENTAL WORK	☐	LYMPH NODE REMOVAL	☐	URINARY PROBLEMS
☐	DEPRESSION	☐	MIGRAINE	☐	VARICOSE VEINS
☐	DIABETES	☐	NECK PAIN	☐	WEIGHT LOSS

IS THERE ANYTHING ELSE I SHOULD KNOW ? IF YES PLEASE ADVISE: ___________________________________

I understand and agree to allow this office to use my personal health information for the purpose of consultation, assessment and treatment. **This office does not release client information to any third parties.** I understand that the massage/bodywork I receive is provided for the basic purpose of relaxtion and relief. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination. I affirm that I have stated all my known medical conditions, and answered 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 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.

________________________________ ________________________

SIGNATURE DATE

©2020 Heal In Hands All Rights Reserved

FOR OFFICE USE ONLY

OPERATIONS: ______________________________

FRACTURES: ______________________ RECENT XRAYS / SCANS: ______________________

ACCIDENTS: ______________________________

PREGNANCIES / BIRTH : ______________________________

HEALTH ISSUES: ______________________________

____

____

____

STRESS LEVEL: ***HIGH / LOW*** EXCERCISE (TYPE & FREQUENCY) : ______________________

WEIGHT: ***OVER / UNDER / AVG*** DIET: ______________________

DRUG THERAPY ***QTY AND FREQUENCY*** : ______________________________

NATURAL REMEDIES / VITAMINS : ______________________________

ANY OTHER RELEVANT HEALTH INFORMATION : ______________________________

ANY OTHER RELEVANT FAMILY INFORMATION : ______________________________

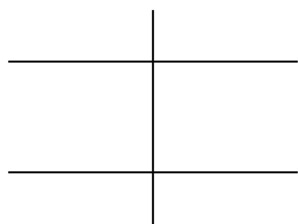
PREVIOUSLY TREATED (GIVE DETAILS) : ______________________________

INITIAL BASIC ASSESSMENT

AREAS OF PAIN **AREAS OF PARAESTHESIAE**

ANTERIOR / POSETERIOR

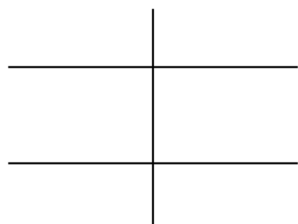
VIEW



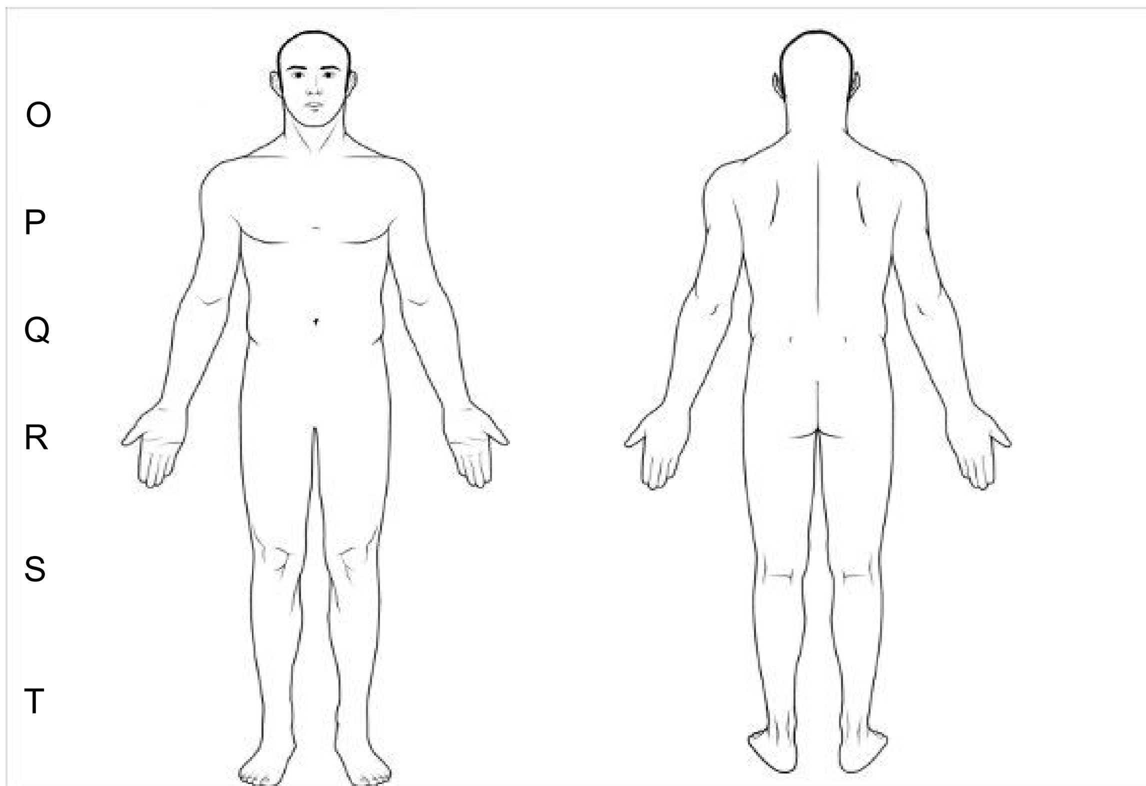
RIGHT / LEFT

SIDE VIEW

ANTERIOR / POSETERIOR



R ANTERIOR L **L POSTERIOR R**



I confirm that I have discussed and agreed to the proposed treatment plan and agree to proceed with my full consent.

______________________ ______________________

SIGNATURE DATE

©2020 Heal In Hands All Rights Reserved