Today's Date: _____

THERAPY WORKS CONFIDENTIAL CLIENT INFORMATION

First Name: _____ M.I. _____ Last Name: _____ DOB: _____

Address:_____City:_____State:_____Zip:_____

Phone: (h)_____ Cell:_____ Email address:_____

Occupation: _____Employer: _____

Emergency Contact name and phone; _____ _____

Relation to emergency contact: _____Marital Status: _____

Referred by: _____

Primary Care Physician: _____

Current Height: _____ Weight: _____ Age: _____ # of Children _____ Ages: _____

Do you wear eye correction? Lenses Glasses Both Pregnant? Y N Maybe

List Previous Occupations:_____

Reason(s) for visit: _____

Check all you have consulted for your symptoms:

___Physician (MD)	___Osteopath	___Chiropractor	___Physical Therapist
___ Naturopath	___Neurologist	___Orthopedist	___Occupational Therapist
___Psychologist	___Psychiatrist	___Counselor	___Massage Therapist
___Acupuncturist	___Biofeedback	___Physiatrist	___Personal Trainer

___Other (specify) _____

Is this your first professional massage? YES NO Last massage treatment: _____

Please state **any recent** injuries, accidents, surgeries or medical treatments with dates: _____

_____

_____

_____

Are you currently under a Physician's care? _____ Whom?:_____

Reason(s) ?

Current Treatments:

List any/all Past Surgeries and Dates:

List all medication/supplements you are taking now or at regular intervals including over the counter such as aspirin:

Medication	Dosage	Frequency	Effectiveness

Rate you area(s) of **current pain** by **circling the number** on the scale of "0" no pain to "10" worst pain possible:

Low back 0 1 2 3 4 5 6 7 8 9 10
Middle Back 0 1 2 3 4 5 6 7 8 9 10
Upper Back 0 1 2 3 4 5 6 7 8 9 10
Neck 0 1 2 3 4 5 6 7 8 9 10
Headache 0 1 2 3 4 5 6 7 8 9 10
Face 0 1 2 3 4 5 6 7 8 9 10
Chest 0 1 2 3 4 5 6 7 8 9 10
Abdomen 0 1 2 3 4 5 6 7 8 9 10
Groin 0 1 2 3 4 5 6 7 8 9 10
Other 0 1 2 3 4 5 6 7 8 9 10

Right Shoulder 0 1 2 3 4 5 6 7 8 9 10
Right Arm or Elbow 0 1 2 3 4 5 6 7 8 9 10
Right Hand or Wrist 0 1 2 3 4 5 6 7 8 9 10
Left Shoulder 0 1 2 3 4 5 6 7 8 9 10
Left Arm or Elbow 0 1 2 3 4 5 6 7 8 9 10
Left Hand or Wrist 0 1 2 3 4 5 6 7 8 9 10
Right Hip, Leg or Knee 0 1 2 3 4 5 6 7 8 9 10
Right Calf, Ankle or Foot 0 1 2 3 4 5 6 7 8 9 10
Left Hip, Leg or Knee 0 1 2 3 4 5 6 7 8 9 10
Left Calf, Ankle or Foot 0 1 2 3 4 5 6 7 8 9 10

Briefly describe your symptoms and include when they began:

6. Did these symptoms begin as an Injury/Accident: NO YES **Date of injury/accident**_____

If Yes, was it: On the Job At Home Sports related Vehicle Related Other
If Vehicle Related: Seatbelt On or Off Driver or Passenger Front or Back Seat

What are your current activities or hobbies?

Has your condition caused you to change or discontinue activities or hobbies? Please explain.

What type of **activities** r**elieve or decrease** your symptoms?

Ice Warm/hot bath or shower Exercise Sitting Resting Nothing Heat
Activity Standing Walking Laying down Relaxation Walking Taping
Wrapping Medication Other (specify) _____

What type of **activities increase your symptoms**?

Ice Heat Rest Sitting Standing Waist Bending Vacuuming Walking
Driving Nothing Loud Noise Laying Down Eye Movements Reaching
Lifting Overhead Reaching or Lifting Head Movements Flashing Lights
Twisting Movements Going to the Bathroom Coughing Sneezing Intercourse
Activities of Daily Living Other (specify) _____

Describe the **pattern of your symptoms**:

Constant Periodic Transient Stabbing Pounding Numbness Dull
Sharp Achy Tingling Throbbing Shooting Tight Hot
Burning Radiating Suffocating Tender Worse on Waking Cold
Worse at End of Day Disturbs Sleep

Circle any **other symptoms** you are experiencing: (**exacerbated by condition or new**)

Anxiety Allergies Dizziness Stiffness Nausea Diarrhea Headaches
Constipation Weight Loss Weight Gain Depression Fearful
Jaw Clenching TMJ Grinding of Teeth Fatigue Sexual Dysfunction
Shortness of Breath Sleep disturbance Limited motion Pain Depression
Emotional Instability Difficulty Swallowing Vision Disturbance Skin irritation
Other (specify): _____

Explain and date any **previous Injuries/Accidents** in which you have been involved:

Primary, Secondary or Collegiate Sports: _____
_____

Hiking Falling Tripping Slipping Stumbling Jamming Stubbing
Bicycling Auto Jet Skiing Motorcycle Bumping or Hitting Head Choking
Open Head Injury Closed Head Injury/Concussion Horseback Riding Dancing
Snow/Water Skiing Snow Boarding Wind Surfing Roller/Ice Skating
Triathlon Marathon Skate Boarding Other (specify) _____

Please **check or list** any conditions or symptoms for which you **<u>have been</u>** or are **<u>currently</u>** being treated:

<u>Skin Conditions</u>:
___Eczema
___Cancer
___Herpes
___Psoriasis
___Athlete's foot
___Ringworm
___Acne
___Bruises
___Other (specify):

<u>Respiratory Conditions</u>:
___Asthma
___Bronchitis
___Collapsed Lung
___Lung disease
___Pulmonary embolus
___Other (specify):

<u>Nervous System Conditions</u>
___Multiple Sclerosis
___Neuroma
___Pinched nerve
___Neuritis
___Loss of sensation/numbness
___Sciatica
___Bulging Disk
___Ruptured Disk
___Other (specify):

<u>Circulatory Conditions:</u>
___Phlebitis
___Blood Clots
___Varicosities
___High/Low Blood pressure
___Heart disease
___Pacemaker

<u>Digestive/Urinary Conditions</u>
___Ulcer
___Colitis/Crohns
___Irritable Bowel
___Gall Bladder/stones
___Bladder infection
___Kidney infection/stones

<u>Muscular/Tendon Conditions</u>:
___Sprain/Strain
___Tendonitis
___Fibromyalgia
___Chronic Stiffness
___Leg/Foot Cramps

___Angina
___Stroke
:___Other (specify)

___Liver Disorder
___Chronic Renal Failure
___Other

___Muscle weakness
___Limited movement
___Other

Osteopathic Conditions

___Broken bones
___Osteoporosis
___Osteoarthritis
___Degenerative hip, shoulder, or knee
___Joint replacement (specify)
___Other (specify):

Lymphatic Conditions:

___Chronic colds
___Chronic flu
___Swollen Lymph Nodes
___Other (specify):

Other Conditions/Symptoms:

___Post Polio
___Cancer
___Ulcers
___Anemia
___Stroke
___Asthma
___Bursitis
___Diabetes (Type 1)
___Diabetes (Type 2)
___Menstrual Cramping
___Ovarian Cancer
___Kidney infections
___Fibromyalgia
___Vertigo
___Ringing in ears/Tinnitus
___Charcot-Marie-Tooth

___HIV+
___AIDS
___PMS
___TMJ
___Gout
___Alcoholism
___Emphysema
___Weight Loss
___Lupus
___Endometriosis
___Cervical Cancer
___Kidney disease
___Fibrocystic Breasts
___Dizziness
___Méniére syndrome
___Shingles

___Rheumatoid Arthritis
___Tuberculosis
___Heart disease
___High or Low Thyroid
___Chronic sinus infections
___Dizziness or Fainting spells
___Nipple tenderness/discharge
___Weight gain
___Raynaud's Syndrome
___Breast Cancer
___Perimenopausal symptoms
___Post menopausal symptoms
___Kidney Stones
___Ovarian Cysts
___Endometriosis
___Other (specify):

Pregnancy: C-Section or Vaginal Delivery

I, _____, am voluntarily wishing to experience a session(s) of therapeutic massage techniques and/or if necessary instruction for self care and home exercises by Dena Halle, LMP, ATC. I understand that massage is not a substitute for seeking medical care or treatment by an M.D. I have alerted my therapist to any conditions I have which may affect the treatment and have disclosed all medications and supplements (prescribed and over the counter), that I am currently taking. I further agree to update my practitioner to any changes in mental, emotional or physical health.

I am seeking therapeutic massage of my own accord or as prescribed by my physician for the purposes that massage therapy is intended in the state of Washington and in accordance to the Law governed by the Department of Health and Licensing.

I agree that all medical information provided is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination.

Signature:_____ **Date:**_____