Structural Integrative Bodywork

Client Health History

Sharing information is voluntary and is designed to improve the quality of service to you. This information is strictly confidential and may be important to your treatment.

Your information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ☐(h) _____ ☐(w) _____ ☐(c) _____

(Please place a checkmark next to your preferred method of contact.)

Email: _____

Occupation: _____

Your age? _____ DOB: _____ Height: _____ Weight: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relationship: _____

Did someone refer you to me?

(please circle) Yes No If yes, who referred you?: _____

What is the reason for your visit?

_____

_____

_____

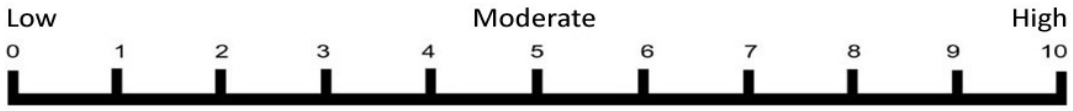
What would you like to gain from treatment?

_____
_____
_____

What are your current daily activities? (list work, exercise, hobbies, etc)

_____
_____
_____

Please indicate your stress level.



Please list all pharmaceutical medications:

_____
_____
_____

Please list any vitamins/supplements your are currently taking:

_____
_____

What are your 3 biggest health challenges currently:

1 _____
2 _____
3 _____
_____

How do your current health challenges limit you?

_____
_____
_____
_____

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

Headaches
Joints stiffness/swelling
Broken/Fractured Bones
Strains/Sprains
Back, hip pain
Shoulder, neck, arm or hand pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other:_____

Nervous System

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Distrophy
Parkinson's Disease
Other:_____

Skin

Bruise easily
Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophelia
Other:_____

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Chron's Disease
Colitis
Other:_____

Illnesses or Disease

Diabetes
Dizziness
Short of breath
Fainting
Cold feet or hands
Cardiac problems
High Blood Pressure
Allergies
Breathing problems
Illness/flu/cold
Other:_____

Gynecological

Pre menopausal
Post menopausal
Hysterectomy
Prolapse/explain
_____
_____
_____
_____

Other

Loss of Appetite
Depression
Difficulty concentrating
Hearing Impaired
Diabetes
Fibromyalgia
Post Polio Syndrome
Cancer
Tuberculosis
Water/day_____
Alcohol/day_____
Nicotine/day_____
Caffeine/day _____

Additional Comments:

_____
_____
_____
_____
_____
_____

Do you have any other conditions that may deserve attention?

_____
_____
_____

Please list any accidents or falls and when they occurred.

_____
_____
_____

Please list any broken bones/fractures and when they occurred.

_____
_____
_____

Please list any SCARS, surgeries, minor and major and when they occurred.

_____
_____
_____

Are you currently receiving any kind of health care treatment? If yes, please specify (conventional/medical or alternative/complementary treatment)

_____
_____
_____

What kinds of Bodywork have you experienced before? How often?

_____
_____

Is there anything else that feels significant to you that you want me to be aware of?

_____
_____

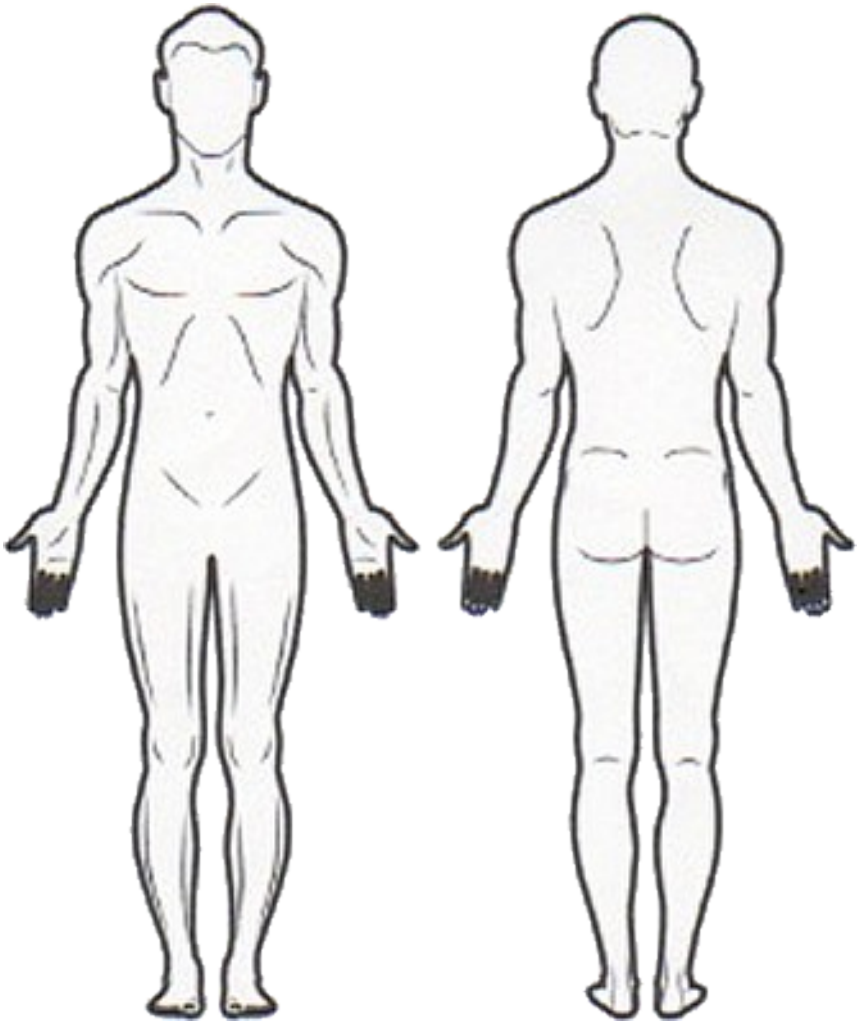
FEMALES ONLY

Are you pregnant ot trying to become pregnant? Yes No

Due date: _____

Do you have children? If yes, how many? _____

Please circle areas of pain or discomfort.



Additional Comments:

Consent For Manual Therapy

I consent to the manual therapy from Lauree Moretto, certified in Structural Integration, Nationally Certified and Licensed Massage Practitioner in the State of Florida.

The course of each session will be determined by your needs at the time of the appointment. There will be a consultation of the beginning of each session to determine your needs.

I give permission to Lauree to work with and touch my body applying whatever techniques appropriate for helping you establish and restore balance and alignment, reduce stress, and self education. This therapy is not medical in nature and is not a substitute for medical attention when needed.

In the course of this session, it is possible that uncomfortable sensations may occur. I understand and agree to be accountable for expressing any concerns so that we can work together.

To be effective and fair to you, my other clients, and Lauree as well, the following policy needs to be acknowledged: Except for emergencies, a 24 hour advance notice is required when canceling your appointment. This time is blocked exclusively for you. I fully understand and agree that I will be charged the full amount for any missed appointments.

All services rendered to me are my personal responsibility and I agree to make payments for these services to the health care provider's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collections of the account.

I understand payment is due at the time of our appointment unless other agreements have been made.

Client Name (printed): _____

Client Signature: _____

Parents or Guardians name, if client is a minor: _____

Date: _____