**CONFIDENTIAL CLIENT HEALTH HISTORY**

Name       Date of birth       Today’s Date

Address                 

Street Address City State Zip code

Home phone       Work phone       Cell phone

E-mail

Occupation       Employer

In case of emergency, notify: Name       Relationship

Emergency Phone No.s: Hm:       Wk:       Cell:

Referred by:       Phone number:

If this is a Health Care Practitioner, do I have permission to send them a report about your progress?

Yes  No

**\*OPTIONAL:** Pronouns        Gender Identity

**COVID-19 Vaccine**: I am fully vaccinated (March 2021, Pfizer). As of July 22, 2021, I am only seeing vaccinated clients in my office. If you are unvaccinated, I am happy to see you for a Zoom session for consultation or Self Manual Lymphatic Drainage.

Vaccination: None:  Dose 1 Date:      Dose 2 Date:      J&J Date:

Health care providers:

* Primary care physician:

Name Phone Number

* Other:

Name Phone Number

* Other:

Name Phone Number

Which of the above do I have permission to contact if appropriate for your care? ***Please place “X” by name(s)***

When was your last physical exam?

Have you had massage or any other bodywork before?  No  Yes Date of last session:

Types of bodywork received:

How much water do you drink on average a day? \_\_     \_\_\_ Ounces per day

Are you pregnant or trying to become pregnant? No Yes # weeks pregnant

Are you currently receiving psychological counseling?

Have you had confirmed or suspected COVID-19? No  Yes - If yes, most recent positive date:

Have you been diagnosed with a particular condition? No  Yes

If so, please explain:

Please mark **C** =**CURRENT** or **P =** **PAST** conditions. Indicate frequency when appropriate:

Abdominal pain

Allergies to

Anemia

Appendicitis

Arthritis

Osteo:

Rheumatoid:

Asthma

Athlete’s foot

Blood clots

Bronchitis

Cancer/tumor:

Benign:

Malignant

Chest pain

ME/CFS

Chronic pain

Concussion

Diabetes: Type 1 2

Difficulty breathing

Disk problems

Dizziness

Ear infection

Ear noise

Eczema

Edema:

Enlarged glands

Epilepsy

Eye disease

Fibromyalgia

Gallbladder trouble

Gas &/or bloating

Gout

Headache – Frequency?

Head injury, date:

Heart disease

Hepatitis A, B, C

Hernia

HIV+

Bp: High Low

Irregular heartbeat

Kidney issues

Lipedema / Lipoedema

Liver disease

Loss of sensation/

numbness

Lupus

Lyme Disease:

Lymphedema

Location:

Primary Secondary

Migraines

Mononucleosis/EPV

Multiple sclerosis

Nausea

Neuralgia or neuritis

Osteoporosis

Pneumonia

Poor circulation

Rashes

Sciatica

Shooting pains

Stroke

Swollen ankles

Tension/anxiety

Whiplash

Information about any of the above or any other condition:

Please indicate either the date of the below events, or approximately how long ago it happened:

No  Yes Broken bones? Strains or sprains?

No  Yes Auto accident?

No  Yes Struck unconscious?

No  Yes Surgeries? Hospitalized?

No  Yes Head Injuries?

Further descriptions of above injuries/accidents/illnesses/surgeries:

List of all prescribed medications:

Med:       For:       More info:

Med:       For:       More info:

Med:       For:       More info:

Med:       For:       More info:

What is your goal for today’s session?

What is your long-term goal?

Do you have any specific areas you would like to address in today’s session?

Are there any areas of your body you would like me to **avoid**? (Check all that apply):

Arms R L Hands R L Legs R L Feet R L Buttock Abdomen Neck Back

Other:

Is there anything else that you feel I should know?

**Client Health Information Acknowledgement**

The health information given on these pages is complete and correct to the best of my knowledge and on future visits I will inform Nina Edgerton of any changes. It is my choice to receive manual therapy and I give my consent to receive treatment. I will inform Nina of any discomfort or pain during the session. I understand that manual therapy is not a substitute for medical treatment.

**Appointments and Fee Information**:

For your appointment, I set aside 60 or 90 minutes, including a discussion of your medical history/progress and exercises or home self-care that may apply to maintaining the benefits of the session.

Fees are listed on the website ninaedgerton.com.. You are responsible for paying these fees beforehand, or at the time of service, rendered by credit card, check or cash.

In-office only - Hivamat 200 / Deep Oscillation Therapy – Add on fee of $20.

I do not bill insurance companies, though I am happy to offer you a receipt for services rendered that you may submit to your insurance company.

**Cancellation and Lateness Policies**:

There is a 24-hour cancellation policy. Notification of cancellation less than 24 hours prior to your appointment, you will be charged the full fee of the appointment scheduled, which will be sent to me by mail. Please call (206) 818-5540 if you need to cancel your appointment.

If you are 15 minutes or more late and I haven’t heard from you, your appointment may be cancelled and you will be charged for the appointment. If you have notified me that you will be late, we will stay with the end-time as scheduled, and the full fee for the session is expected.

**Client Acknowledgment**:

I have read and understand the contents of this disclosure and agree to abide by these policies.

Client:       Date:

**HIPAA**

I give Nina Edgerton permission to share records and pertinent health information with other qualified Health Care Practitioners for the purpose of benefiting my plan of care.

Client:       Date: