Therapeutic Massage by Lauren Piro
Holistic Health History and Lifestyle Form

First Name _____ Last Name _____ Date _____

Address _____ City/State/Zip _____

Cell Phone _____ Email _____

DOB _____ Referred By _____

Emergency Contact _____ Relationship _____ Phone _____

What are your health goals, and how may I assist you in achieving them?_____
_____
_____

Have you had a professional massage or bodywork before? Yes _____ No _____ How recently? _____
If so, what kinds? _____

What kind of pressure do you generally prefer? Light _____ Medium _____ Firm _____

Are you or might you be pregnant? Yes _____ No _____ Maybe _____ Due Date: _____

Please list frequent daily activities, including how you use your body at work, home, in hobbies, exercise, etc:
_____
_____

Have you used your body in any way that's out of the ordinary recently? Yes _____ No _____
If so, how? _____

Are you presently under the care of a physician, chiropractor, physical therapist, or psychiatrist? Yes _____ No _____
If so, for what? _____

Are you currently recovering from an accident, injury, or surgical procedure? Yes _____ No _____
If so, please describe and provide approximate date: _____

Please list any medications or pain relievers taken this week, including frequency, dosage, and any side effects:
_____
_____

Please list any allergies or skin sensitivities: _____
_____

Are you currently experiencing symptoms of any of the following conditions:
Not currently ill _____ Fever _____ Cold _____ Flu ____ Viral/Bacterial Infection _____ Contagious Disease _____

What is your current level of stress?
Not stressed _____ Mildly stressed _____ Moderately stressed _____ Very stressed _____

How would you describe your activity level?
Sedentary _____ Limited activity _____ Moderate activity _____ Highly active _____

How would you describe your energy level?
Lack of energy _____Low energy _____ Moderate energy _____ High level of energy _____

Please indicate how much of the following you consume each day or week:
Water _____ Caffeine _____ Alcohol _____ Tobacco _____ Sugar _____

Please indicate below any of the following **musculoskeletal** conditions that you have experienced:

___ No known issues	___ Spasms/Cramps	___ Sprains/Strains	___ Fractures
___ Torn Ligaments/Tendons	___ Postural Deviations	___ Tendonitis	___ Bursitis
___ Osteoporosis	___ Osteopenia	___ Osteoarthritis	___ Rheumatoid Arthritis
___ Thoracic Outlet Syndrome	___ Torticollis	___ TMJ Disorder	___ Whiplash
___ Frozen Shoulder	___ Carpal Tunnel	___ Scoliosis	___ Sciatica
___ Herniated/Bulging Disc	___ Plantar Fasciitis	___ Gout	___ Neck Pain
___ Shoulder Pain	___ Wrist/Forearm Pain	___ Back Pain	___ Hip Pain
___ Knee Pain	___Ankle Pain	___ Foot Pain	___ Other

Please indicate below any of the following **cardiovascular** conditions that you have experienced:

___ No known issues	___ Stroke	___ Heart Disease	___ Heart Attack
___ Hypertension	___ Low Blood Pressure	___ Diabetes	___ High Cholesterol
___ Hemophilia	___ Anemia	___Hypoglycemia	___ Varicose Veins
___ Blood Clots	___ Edema	___ Other	

Please indicate below any of the following **neurological** conditions that you have experienced:

___ No known issues	___ Fibromyalgia	___ Multiple Sclerosis	___ ALS
___ Parkinson's Disease	___ Seizure Disorders	___ Spinal Cord Injury	___ Bell's Palsy
___ Trigeminal Neuralgia	___ Neuritis	___ Numbness/Tingling	___ Other

Please indicate below any of the following **skin** conditions that you have experienced:

___ No known issues	___ Warts	___ Fungal Infections	___ Athlete's Foot
___ Eczema	___ Psoriasis	___ Burns	___ Rash
___ Open Sores/Wounds	___ Acne	___ Bruise Easily	___ Other

Please indicate below any of the following **digestive** conditions that you have experienced:

___ No known issues	___ GERD	___ Ulcerative Colitis	___ Crohn's Disease
___ Irritable Bowel Syndrome	___ Ulcers	___ Acid Reflux	___ Indigestion
___ Gas/Bloating	___ Constipation	___ Diarrhea	___ Other

Please indicate below any of the following **respiratory** conditions that you have experienced:

___ No known issues	___ Emphysema	___ COPD	___ Asthma
___ Hay Fever	___ Sinusitis	___ Bronchitis	___ Pneumonia
___ Dizziness	___ Trouble Breathing	___ Other	

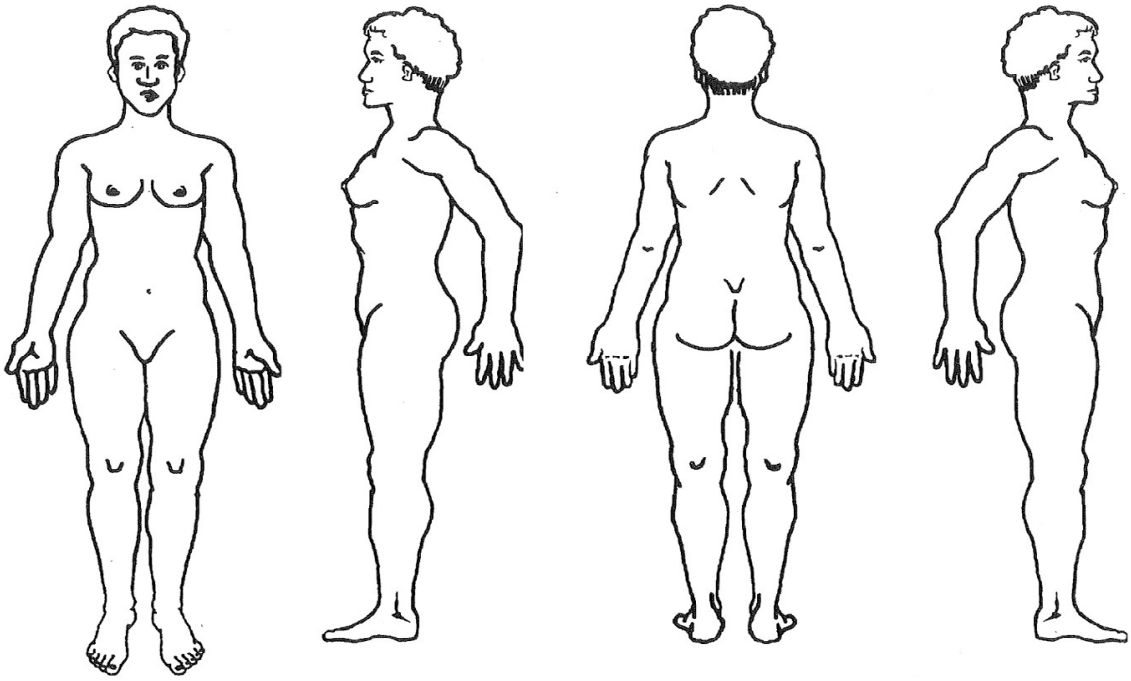
Please indicate below any of the following **psychiatric** conditions that you have experienced:

___ No known issues ___ Depression ___ Anxiety ___ Panic Attacks
___ Postpartum Depression ___ Bipolar Disorder ___ Eating Disorder ___ PTSD
___ Physical/Emotional Abuse ___ Grief Process ___ Substance Abuse ___ Other

Please indicate below any of the following **other** conditions that you have experienced:

___ No known issues ___ Headaches ___ Migraines ___ Sleep Apnea
___ Chronic Fatigue Syndrome ___ Insomnia ___ Thyroid Disorder ___ Kidney Disease
___ Hepatitis ___ Liver Disease ___ Lyme Disease ___ Lupus
___ Fibroids/Ovarian Cysts ___ Endometriosis ___ Dysmennorhea ___ PMS
___ Cancer: _____
___ Other: _____

Please indicate any **scars** on the diagram, as well as areas where you are experiencing **pain/discomfort** (x), **numbness** (-), **tingling** (+), **swelling** (o):



Please indicate which benefits you are hoping to gain from therapeutic massage:

___ general relaxation
___ reducing mental stress and/or fatigue
___ relief from muscle tension
___ reducing pain/spasm/stiffness
___ relieving tension headaches and/or migraines
___ reducing anxiety and/or depression
___ reducing and realigning scar tissue fibers
___ reducing strain and dysfunction in joints
___ increasing body awareness
___ increasing energy
___ reducing inflammation
___ improving circulation
___ enhancing immune system function
___ reducing the risk of sports related injury
___ enhancing athletic endurance and performance
___ improving recovery time between workouts
___ improving flexibility, mobility, and/or range of motion
___ improving posture
___ connecting and grounding the mind-body-spirit
___ promoting balance and coordination

Practice Policies

Communication: I am aware that by electing to receive therapeutic massage, I am entering into a partnership between me and my therapist. While I understand my therapist will check in to ensure I am comfortable during my treatments, I am responsible for communicating my needs and preferences to my therapist, especially regarding technique, pressure, pain, or other sensations I may experience. I will also communicate any discomfort with hot and/or cold applications, room temperature, lighting, music, etc. Appropriate requests within my therapist's scope of practice will be honored to the extent that they are possible.

Arrival Time: For my first appointment, I will arrive 10-15 minutes early for my consultation to formulate a treatment plan for my session. To maximize my massage time, I will print and complete the forms ahead of time. For subsequent sessions, I will arrive 5-10 minutes early to settle in and update my treatment plan before my session.

Cancellations/Rescheduling/No Shows: I will provide at least 24 hours notice should I need to cancel or reschedule my appointments to allow ample time to fill my slot and avoid incurring a missed appointment fee. For any changes within 24 hours, I will be billed half the cost of the sessions. If I do not show, I will be billed the full cost of the session. Any cancellations within three hours of my appointment time will be considered a No Show. I must make the payment before my next appointment will be scheduled.

Illness: I am aware that there are times when massage is contraindicated, and could actually intensify and prolong my illness. If I feel I am getting sick, or if I have an active cold, flu, cough, sore throat, stomach virus, undiagnosed skin rash, or anything potentially contagious, I will reschedule my appointment as soon as I become aware.

Payment: Payment is due when professional service is rendered. Payment is accepted by cash, check, credit, debit, HSA/FSA accounts. I agree to pay a $25 fee for returned checks.

Non-sexual: All services are strictly professional and non-sexual in nature. Any overt or suggestive statements or actions will result in termination of my session and the therapeutic relationship, and payment will be due in full. I understand that law enforcement may be contacted if I engage in such behavior.

Confidentiality: All information provided will be kept strictly confidential, except where mandated by law.

Medical Treatment: I understand that therapeutic massage shall not substitute for medical examination, diagnosis, or treatment, and no information imparted during the session should be construed as such. I understand that there are conditions under which massage may be contraindicated and it may be necessary to see a physician or provider.

Contact: I understand there are times that my therapist may need to contact me for appointment reminders, schedule changes, or other needs, and I have provided accurate contact information at which I can be easily reached.

I would ___ would not ___ like to receive the newsletter with updates, specials, and research and health information.

I would ___ would not ___ like to receive the Last Minute Opening Email Blasts.

By signing below, I attest that the information I have provided is complete and accurate to the best of my knowledge. I understand and agree to adhere to the practice policies noted above. I agree to inform my therapist of any changes in my medical status. I will not hold Therapeutic Massage by Lauren Piro or my therapist liable for any effects from my session and I consent to treatment.

Signature _____ Date _____