Matriarch Massage & Wellness

My mission is to help you figure out your personal health and wellness issues and how they intersect and affect your life. I work with men and women who are fatigued or suffering from chronic pain. My goal is to guide you to feeling well again. **Heather Brown--LMT, Health Coach & Advanced FSM Practitoner**

Health History

Please write or print clearly. All of your information will remain confidential.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Email: _____

Phone: Home: _____ Work: _____ Mobile: _____

Birthdate: _____ Place of Birth: _____

Relationship status: _____

Address: _____

Do you work or live in a farming/rural area? Yes ___ No ___ | Have you ever worked or lived in a farming area: Yes ___ No ___

Children: _____ Pets or farm animals: _____

Occupation: _____ Hours of work per week: _____

HEALTH INFORMATION

Please list your main health concerns: _____

_____

_____

Other concerns and/or goals? _____

_____

At what point in your life did you feel best? _____

Any serious illnesses/hospitalizations/injuries/traumas as child or adult?_____ _____

Any surgeries, accidents, head/neck injuries, concussions as a child or adult? _____

_____

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HEALTH INFORMATION (continued)

How is/was the health of your mother? _____

How is/was the health of your father? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____ Why?_____

Do you sleep on your stomach? _____ Daily Water Intake: _____oz. | Filtered? _____

Any pain, stiffness, or swelling? _____

If female are you pregnant or could you be?_____Due Date:_____

Constipation/Diarrhea/Gas? _____

Allergies or sensitivities? Please explain: _____

Any scent allergies?

_____

MEDICAL INFORMATION

Do you take any supplements or medications? Please list: _____

_____

_____

Have you had your vitamin D levels checked and do you supplement?_____

Any healers, helpers, or therapies with which you are involved? Please list: _____

_____

What role does sports and exercise play in your life? _____

_____

What are your goals for treatment?

_____

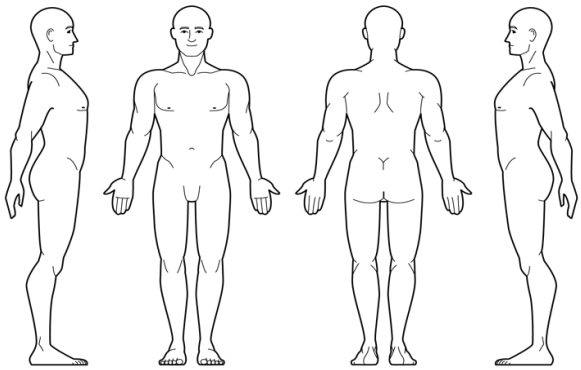
If massage: Have you had a professional massage before?

Yes ___ No ___

What type of massage are you seeking?

Relaxation___ Therapeutic ___ Deep Tissue ____

Please circle any areas of discomfort:



What pressure do you prefer? Light __ Med ___ Deep ___

What kinds of conditions run in your family?

Please check or circle any that apply to you or a family member. **If yes please note who and if treatment was successful.**
Alcoholism
Alzheimer's/Dementia and age of onset _____
Arthritis
Asthma or chronic lung complaints
Blood clots
Cancer
Dental issues (Root canals, etc.)
Depression
Diabetes
Digestion complaints or food allergies (Celiac, Crohn's)
Disc degeneration
Drug addictions (heroine/opiates, etc.)
Exposed to mold or damp environment
Fibromyalgia
Heart Disease/Pacemaker
High Blood Pressure
Kidney Disease
Liver failure
Lupus
Mental Illness/Bi-Polar/Anxiety
Migraines/Headaches
Parkinson's
Rheumatism
Stroke
Traumas (abuse of any kind)
Viruses or infections? (Skin issues, Herpes, Lyme, EBV, etc.)
Comments or other conditions:
Have you had any diagnostic studies and please note for what condition and the approximate year(s):
MRI
Bone Scan
CAT Scan
X-Rays
Colonoscopy
Chemo or radiation of other kind
Mammogram
Any others or comments:

What was going on in your life in the year preceding the onset of the condition(s) that are your main concerns?

_____

FOOD INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you cook? _____ What percentage of your food is home-cooked? _____

Where do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

_____

The most important thing I should change about my diet to improve my health is?: _____

_____

ADDITIONAL COMMENTS

Anything else you would like to share? _____

_____

By signing below, I agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform Heather Brown if any of the above information changes. I will also let Heather know ASAP if I experience any pain or discomfort during or after a session. I will also come to my sessions properly hydrated and hydrate afterward to reduce my odds of experiencing any nausea or discomfort from an FSM treatment.

Client Signature: _____ Date: _____

Please return to: Prevention and Healing of Iowa
Attn: Heather Brown, 2650 - 106th St. Suite 100, Urbandale, Iowa 50322
Questions? Call, text or email Heather: 515/689-2001 matriarchmassage@gmail.com