

Anne Speer
Integrative Bodywork
CranioSacral Therapy

Confidential
Client Information

Completion of this confidential form is required for all clients on their first visit to allow me to be accurately informed of any past or present conditions that may affect the course of your treatment. I also ask that you keep me up-to-date with this information as it changes, as this is part of your treatment record.

Name _____ Date of Birth _____

Address _____

City State Zip Code _____

Home # _____ Cell # _____

E-mail Address _____

Occupation _____

Emergency contact name (relationship) and phone _____

My major area of concern is _____

How long have you had this condition ? _____

Specific diagnosis received ? _____

This condition or pain is: intermittent constant getting progressively worse getting better

Please mark your level of pain on the scale: no pain=0 _____ 5 _____ 10=worst pain

It interferes with: work sleep daily routine exercise other doesn't interfere

I think my symptoms may be caused or affected by: _____

Who else have you seen for this condition ? _____

Please list any major surgeries, accidents, injuries you have had:

Any allergies to: Latex Oils/Lotions, specify _____
 Medications, specify _____

Health history

Musculoskeletal

- Bone or joint disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw Pain (TMJ)
- Lupus
- Spinal Problems
- Migraines/Headaches
- Osteoporosis

Circulatory

- Heart Condition
- Varicose Veins/Phlebitis
- Blood Clots
- High/Low Blood Pressure
- Lymphedema
- Thrombosis/Embolism

Nervous System

- Shingles
- Numbness/Tingling
- Pinched Nerve
- Chronic Pain
- Paralysis
- Multiple Sclerosis
- Parkinson's Disease

Respiratory

- Breathing Difficulty/Asthma
- Emphysema
- COPD
- Sinus Problems
- Allergies, specify:

Digestive

- Irritable Bowel Syndrome
- Bladder/Kidney
- Colitis
- Crohn's Disease
- Ulcers
- GERD

Skin

- Allergies, specify:

- Rashes
- Cosmetic Surgery
- Athlete's Foot
- Herpes/Cold sores
- Scars

Psychological

- Anxiety/Stress Syndrome
- Depression

Reproductive

- Pregnant, stage _____

Other

- Cancer/Tumors
- Diabetes
- Dentures
- Hearing Aids

Please list any medications you are currently taking:

I understand that a Massage Therapist does not diagnose illness, injury or any other medical or physical disorder. I also understand that my Massage Practitioner must be made aware of any existing physical conditions, and I agree to keep my Practitioner informed of any changes in my status for my records.

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility and are due and payable at the time services are rendered.

Signature of Client/Guardian

Date

