ERIN KELLY

MASSAGE THERAPY & YOGA

CLIENT HISTORY

Please complete this form before your first Massage Therapy session and bring it with you to your appointment. Thank you.

Client Name: _____ DOB: _____

Address:: _____ City: _____ State _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

How did you hear about Erin Kelly? _____

Emergency Contact

Name: _____ Phone _____

Relation to Client: _____

Medical History

Do you have Chronic Muscular Pain (and/or Fibromyalgia)? If so, for how long?

_____

_____

_____

If yes, When did you notice the symptoms?

_____

If yes, was there an event or illness that started the pain?

_____

Please list any accidents (e.g. car, bicycle) or surgeries you have undergone, starting with the most recent:

Date of accident/surgery	Accident/Surgery
_____	_____
_____	_____
_____	_____

Have you been told by a physician that you have the following:

Herniated or Bulging Disks	Yes / No
Diabetes	Yes / No
Spinal Stenosis	Yes / No
Scoliosis	Yes / No
Thyroid problems	Yes / No
Arthritis	Yes / No
Osteoporosis	Yes / No
Blood Clots	Yes / No
High or Low Blood Pressure	Yes / No
Heart Attack/Stroke	Yes / No
Are you pregnant?	Yes / No

Do you have any open wounds, warts, cuts, rashes or any contagious infections on your skin? Yes / No

Do you have any allergies? If so, please list _____

_____

Do you experience headaches? If so, how often? _____

_____

If so, please describe sensation and location (ex, over eyes, back of head,) _____

_____

Have you had any of the following: MRI, X-Rays, CAT Scan, EKG, Other

_____

Test Date Performed Findings

_____ _____

_____ _____

_____ _____

Do you currently wear shoe orthotics? Yes / No

If yes, how long have you been wearing them? _____

Do you now, or did you as a child, prefer to sit on one leg? Yes / No

Please circle other therapists you are currently seeing or have seen in the past:

Chiropractic Physical Therapy Acupuncture Massage

Other: _____

List any medications you are currently taking:

1. _____
2. _____
3. _____
4. _____

List any medications you have tried in the past and the reason you stopped taking it:

1. _____
2. _____
3. _____
4. _____

PLEASE NOTE: If any of the following apply, Please call Erin (773) 569-1015 to discuss before your first appointment. In certain cases, massage therapy can be harmful to your health. In certain cases, clearance from other medical professionals may be required.

- Pregnancy
- Heart Attack or Stroke
- ANY illness affecting major organs or systems of the body (ex. cancer)
- Currently or recently taking any form of blood thinner
- Currently or recently undergoing chemotherapy or radiation treatment
- Currently or recently (within 3 days) experiencing flu or cold like symptoms
- Currently experiencing any infections/rashes of the skin
- Recent surgery (within 6 months)

Personal Wellness

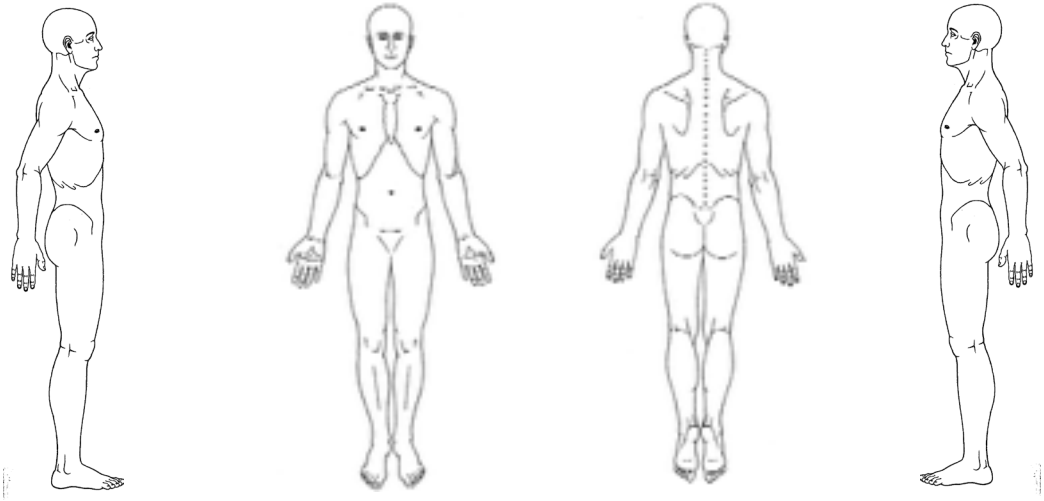
What are your goals to improve the quality of your life?

1. _____
2. _____
3. _____

Patterns/Body Chart

Refer to the body chart below. Shade in the area(s) where you are experiencing soreness/ tension/pain. You can draw lines to indicate specific regions, or add any descriptive words to specify what you are feeling in that region, e.g., burning, sharp, shooting, dull, aching, numbness, tingling.

Right Side R L L R Left Side



Does anything increase the unwanted sensation in the area(s) indicated? If yes, please explain.

_____

_____

Does anything relieve the pain (tension, soreness), e.g., medication, heat, cold?

_____

_____

Is the pain (tension/soreness) associated with any movements you make?

_____

_____

Do you experience any pain (tension, soreness) in the morning? If so, please describe.

Does the level of pain (tension, soreness) increase, decrease, or stay the same in the evening before bed?

At certain times of the month/week does the sensation of pain, tension or soreness change? If so, ,how?

Work Stress

Are you able to work? Yes / No

If yes, what is your occupation?

Is your pain affecting you at work? If so, please describe.

Do you perform repetitive movement at work? Yes / No

Are you immobile for long periods? Yes / No

How do you feel after a day of work?

Home Stress

Do you have childcare or home-tasks? Yes / No

Are you immobile for long periods? Yes / No

Do you read while laying on a couch/bed? Yes / No

Exercise/Stress

Are you able to exercise? Yes / No

If yes, what type of exercises do you do and how frequently? Please be specific.

_____

If not, what are your reasons for not exercising?

_____

What kind of exercises do you think you would enjoy doing?

_____

How stressed are you from day to day (please circle)?

High High-Medium Medium Medium-Low Low

Sleep

What position do you most often sleep in? (circle)

Back Side Stomach Arms Overhead

Half-stomach/half side Fetal position Pets in bed Spooning with partner

If you sleep on your back:

Do you use pillows under the knees? Yes / No

If you sleep on your side:

Do you use any pillows between the legs? Yes / No

Do you use any pillows at the chest? Yes / No

How often do you sleep in each position? _____

Are there any reasons you sleep in these positions? _____

How many hours of sleep do you typically get? _____

Do you have difficulty falling asleep? Yes/no

Do you wake up often in the middle of your sleep? Yes/no

Do you wake up feeling tired? Yes/no

Smoking/Alcohol/Caffeine/Sugar

Do you smoke or use tobacco products? Yes / No

If yes, what kind and how much per day?

_____

Do you drink alcohol? Yes / No

If yes, what kind and how often?

_____

Do you drink caffeinated beverages? Yes / No

If yes, what kind and how often?

_____

Do you frequently eat food with high amounts of sugar/carbohydrates? Yes / No

If yes, what kind and how often?

_____

Water/Supplements

How much water do you drink a day?

_____

Please list any vitamins, minerals, and supplements you are currently taking:

1. _____
2. _____
3. _____

Jaw/Facial Pain

Do you have TMJ? Yes / No

Do you have jaw pain associated with chewing or yawning? Yes / No

Do you clench or grind your teeth? Yes / No

When was your last dental appointment? _____

When was your last eye exam? _____

Do you wear bifocals/trifocals? _____

Do you wear a night guard or mouth splint? Yes / No

Consent for Care

I, _____ understand that massage therapy is indicated for relaxation, improvement of circulation, and relief from muscular and myofascial discomfort. I have completed this Client History form to the best of my knowledge and will keep my massage therapist informed of any changes to my medical history. I understand that the information provided here is confidential and will be used to inform a safe and effective treatment plan.

Cancellation Policy

Giving as much notice as possible in the event that you need to cancel or reschedule your session is greatly appreciated. Please note that a fee of $50 will be charged for cancellations made within 24 hours of the scheduled time and that NO-SHOWS (cancellation made without any notice) will be charged the full amount of the missed session before future appointments can be made. Payment is due at the time of service. Cash or checks only, please.

Signature _____ Date _____

Parent's Signature (If Minor) _____ Date _____

Thank you for you!