HEALTH CONNECTIONS: MASSAGE & COLON HYDROTHERAPY

Confidential Client Information

PLEASE COMPLETE BOTH SIDES

The following questions are designed to help the therapist work within your medical history. If there is any additional information or concern we need to know, please inform the therapist before your session.

NAME_____ DATE_____

ADDRESS_____

(____)_____-_____ (____)_____-_____ _____

HOME NUMBER MOBILE NUMBER E-MAIL

____/____/_____

DATE OF BIRTH EMPLOYER OCCUPATION

Notify in Case of Emergency: _____ (____)_____-_____

Name Telephone Number Relationship to Client

Referred By_____

Insurance Co._____ Phone_(____)_____-_____

Policy Number_____Contact Person _____ _____

Phone

SSN# _____-_____-_____ Date of Injury_____/_____/_____

PRESENT STATUS

What physical symptom(s) caused you to come today?_____

_____

When did you first notice these symptom(s)? _____ What caused the symptoms(s)?_____

_____What activities aggravate the symptom(s)?_____

_____

Is it worse? ___Yes ___No ___Remains Constant Is it interfering with ___Work ___Sleep ____Daily Routine

What have you done in the past for relief?_____

Has there been a medical diagnosis? ____Yes ____ No If yes, what was it?_____

By whom?_____

Address Telephone

Have you ever had a similar problem? ____ Yes _____ No If yes, when and what relieved the symptom(s)_____

_____

MEDICAL STATUS

Are you on medication? __ Yes __ No If yes, what:_____

_____

Are you taking any of the following? Check all that apply and identify when needed.
___ Sleeping Pills / Anti-Anxiety _____ ___Aspirin _____
___ Insulin _____ ___Supplements _____

Please indicate if you have any of the following. Clearly explain in the space provided

O High/Low Blood Pressure _____ O Edema _____
O HIV+/Aids tested _____ O TB Tested _____
O Heart Condition _____ O Stroke _____
O Varicose Veins _____ O Blood Clot _____
O Cancer (specify type) _____ O Fibromyalgia _____
O Muscle Aches/Pains_____ O Joint Pain _____
O Neck / Shoulder Pains _____ O Arthritis _____
O Low Back Pain _____ O Joint Replacements _____
O Middle Back Pain _____ O Herniated / Bulging Discs _____
O Fatigue / Insomnia _____ O Depression _____
O History of Prostate Trouble _____ O Headaches _____
O Persistent Abdominal pain _____ O Diabetes _____
O Constipation _____ O Infection(s) _____
O Urination Difficulty _____ O Dizziness _____
O Hematomas _____ O Other _____
O Bruise Easily _____ O Other _____
O Accident / Trauma _____ O Surgeries _____

HABITS	NONE	LIGHT	MODERATE	HEAVY
Tobacco				
Caffeine				
Sugar				
Exercise				
Alcohol				
Water Intake				

Sleep Position O Side O Back O Stomach

Do you wear O Dental Appliance O Braces O Heel Lifts O Arch Supports O High Heels

I understand that all therapeutic services performed are by a licensed massage therapist and any potential risks to myself have been considered and accepted. I release this clinic and its staff from any liability due to injury or other causes resulting from the exercise of their duties. I consent to the therapeutic massage/soft tissue mobilization techniques considered appropriate and I understand that the services offered are not a substitute for medical care. Any behavior deemed sexually inappropriate will result in termination of treatment at full cost. Appointments canceled with 24 hours of scheduled time mandates a charge of 75% of fee jf the therapist is unable to reschedule that time.

_____ _____

Date **Client Signature**

Health Connections: Massage & Colon Hydrotherapy, Inc

RELEASE: I understand and agree that massage therapy services provided by *Candice Klein Gordon, LMT, CT,* a state licensed massage therapist, is provided pursuant to and in accordance with the laws of the state of Florida governing massage therapy. I am aware of and understand that full and complete medical disclosure is essential to the massage therapist providing this therapy. By signing this release, I hereby declare that I have provided the therapist with all relevant information necessary for the proper application of massage therapy and that I have made an informed choice to proceed with the treatments. I am fully aware that the massage therapist is not a doctor and will refrain from diagnosing and prescribing and that I may seek medical advice. _____initial

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Services rendered are payable at time of service unless special arrangements have been made in advance of treatment. _____initial

There is a $35 charge for returned checks. _____initial

Appointments may be rescheduled one time with no penalty. A $50 fee will be charged for subsequent rescheduling. Please be sure of your schedule before committing to an appointment and please choose your date and time carefully to fit your schedule. _____initial

There is a $50 charge for appointments cancelled less than 24 hours in advance and FULL FEE charged for missed appointments.
_____initial

Thank you for your courtesy to myself and to others desiring therapy.

Signature_____

Date_____