HEALING MASTERS
body mind soul enrichment

CERTIFIED PROVIDER
IASIS TECHNOLOGIES
MCN: MICRO CURRENT NEUROFEEDBACK

CLIENT HEALTH HISTORY & INTAKE FORM

Date: _____

Name: _____

Address: _____

City/State/Zip Code: _____

Phone :(h) _____ (w) _____(c) _____

DOB: _____/_____/_____ Age: _____ Sex: _____

Occupation: _____

Where May I Email You? _____

Would you like to receive my monthly newsletter? (Please circle one) YES NO

Emergency contact: _____

Relationship to Client_____ Phone: _____

Primary Health Care Provider: _____ Phone: _____

Have you ever had a massage before? (Please circle one) YES NO If yes, most recent: _____

Please list current medications/ Supplements & dose: _____

_____

Please list any known allergies _____

_____

Family History (G= grandparents, P = parents, S = self)

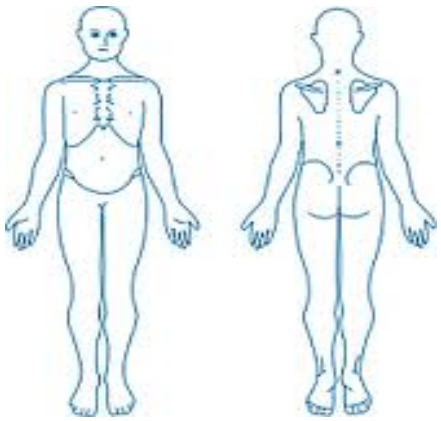
Cancer	G	P	S	Thyroid	G	P	S	Mental illness	G	P	S
Heart disease	G	P	S	Diabetes	G	P	S				
Lung disease	G	P	S	Autoimmune	G	P	S				

Using the pain scale below, how would you rate your discomfort?

Today: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

Typical day: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

Please **circle** the areas of your body that you may be experiencing pain or tension, or you feel you need the **most** attention during session. Please place an **"x"** over the areas you wish to have avoided.



What do you do for relaxation? _____How many times per week do you exercise? _____

Do you have any ongoing chronic conditions?

_____

Have you had an hospitalizations/surgeries (including cosmetic) & or serious illnesses or injuries since birth?

_____

Are you currently under the care of a Health Care Provider i.e. doctor, chiropractor, therapist? (If yes, please explain)

_____

Have you used/are you using, Birth control pill or hormones? _____
(Y = yes, N = No. P =past)

Alcohol Y N P	Antacids Y N P	Addiction Y N P
Smoking Y N P	Laxatives Y N P	
Steroids Y N P	Pain meds Y N P	

How many glasses of alcohol a week? _____
How much do you drink of: ____water _____ tea _____ coffee per day? Do you wear contacts? _____
Roughly how many dairy products do you consume in a week? _____

Have you taken any antibiotics in the past 2 years? How long were you taking them? Y or N
Are you pregnant, breastfeeding or planning a pregnancy in the near future? Y or N
Are you allergic to latex? (If yes please elaborate on severity of previous reactions?)
_____
Do you have any other allergies/intolerances to foodstuffs, drugs, chemicals, etc?
_____

Please **circle** if you are experiencing or have experienced any of the following & *Use C = current or P = past*

Integumentary
Boils / Cysts/ Warts
Fungal Infections
Herpes simplex
Eczema
Psoriasis
Skin cancer

Circulatory
Anemia
Thrombophlebitis
Heart disease
High blood pressure
Varicose veins
Diabetes
Clotting disorders
PAD
Restless Leg Syndrome

Lymph Immune
Edema
Hodgkin's disease
AIDS, HIV
Chronic fatigue syndrome

Nervous Disorders
Multiple sclerosis
Headaches/Migraines
Peripheral neuropathy
Seizure disorders
Post polio syndrome
Stroke
Tinnitus
Dyslexia/Dyscalculia
Speech Problems
Dizziness/Motion Sickness

Urinary
Kidney stones
UTI's
Bladder Infections

Reproductive
Breast/Prostate cancer
Endometriosis
Ovarian cysts
Painful menstruation/Cramping
Mastectomy
Miscarriage(s)
Female Organs
Male Organs
Morning Sickness
Labor Issues
Hysterectomies

Respiratory
Bronchitis
Emphysema
Pneumonia
Tuberculosis
Asthma
Emphysema
Sinusitis
Postnasal drip
Closed/Full Sinuses
Thick mucus
Congestion
Tuberculosis

Cardiovascular
Visceral Problems
Hypertension
Heart Attack
Stroke
Fainting Spells

Ear, Nose, Throat
Earache
Jaw Pain (TMJ)
Hypoglycemia
Sinus Problems
Vertigo
Hearing Loss

Musculoskeletal - Skeletal
Fibromyalgia
Rheumatoid arthritis
Osteoarthritis
TMJ dysfunction
Strains, sprains, tendonitis
Carpal tunnel syndrome
Thoracic outlet syndrome
Sciatica
Spinal Misalignments
Coccygeal Trauma
Upper Back Pain
Lower Back Pain
Fusions
SI Problems
Scoliosis
Whiplash
Arthritis
Frontal Injuries
Poor Posture
Facial Trauma

Digestive
Cirrhosis
Ulcerative colitis
Diverticulitis
Gallstones
Hepatitis
Irritable bowel syndrome/ Crohns Disease
Ulcers
Diabetes
Constipation/ Diarrhea

Abuse
Physical Abuse
Sexual Abuse
Mental Abuse

Endocrine
Adrenal
Pituitary
Lupus
Allergies
Cancer
Fever (Severe)
Hyperthyroid
Hypothyroid

Emotional/ Psych
Depression or Anxiety
Eating Disorder
Mood Swings / Irritability / Anger / High strung
Suicidal / Fear / Guilt
ADD/ADHD/LDD
PTSD / Panic / OCD

Misc.
Sleep Problems / Insomnia
Memory Issues
Bruxism/Clinching
Constant Stress
Clicking/Crepitus
Birth Trauma
Infant & Childhood Disorders
Food Addiction / Eating Disorder

PLEASE *INITIAL* THE FOLLOWING STATEMENTS (1 – 3 for massage)

1) I am aware that draping will be used during this massage session. _____

2) I understand that it is Not within the scope of massage session for the Therapist to engage in breast massage of clients. _____

3) I understand that my feedback is an essential element in my treatment, Therefore if at any time I should become uncomfortable during the massage, I may bring it to my therapist's attention and request that the session end. _____

4) **If I am unable to keep an appointment, I understand that a 24-hour notice Is required, otherwise, I will be charged for the time reserved.** _____

I understand that massage therapy is not a substitute for medical examination or diagnosis, and that I should see a Health Care Provider to address concerns that are outside the scope of a massage therapist's practice. The Massage Therapist does not diagnose or prescribe medication for medical illness, disease, or any other physical or mental disorder. I am aware that massage is contraindicated for some medical conditions, and I affirm that I have answered all questions truthfully to the best of my knowledge and agree to update the therapist on any changes in my health status and medical history. I agree to inform the therapist of any pain experienced during the initial and subsequent sessions, and furthermore understand that I have the right to refuse any treatment or ask that it be modified in regard to pressure or modality.

Client Signature: _____Date: _____

Any one under 16 must have a parental signature. _____ Relationship _____

Practitioner Signature: _____Date: _____

REVIEW OF SYMPTOMS:

1. PAIN:

   A. Headaches:
   How often? _____
   Location? _____
   Severity? _____

   History of Migraine headache? Yes No
   Triggers: _____

   B. Body/joint/limb pain? Please describe:
   _____
   _____

   Fibromyalgia? Yes No
   Photophobia (sensitivity to light)? Yes No
   Hyperacusis (sensitivity to/pain from sound)? Yes No

   What makes your pain better? _____
   What makes your pain worse? _____

2. SLEEP:

   Do you have difficulty falling asleep? Yes No
   Do you have difficulty staying asleep? Yes No
   How many hours do you sleep per night? _____
   How many hours' sleep do you need? _____
   Do you wake feeling rested? Yes No
   Nightmares? Yes No

Additional comments:
_____
_____
_____
_____
_____

3. FOCUS/CONCENTRATION/MEMORY:

ADD/ADHD? Yes No Medication/Treatment: _____
Poor concentration? Yes No
Impulsivity? Yes No
Difficulty making decisions? Yes No
Easily distracted? Yes No
Racing thoughts? Yes No
Disorganized? Yes No
Overwhelmed by stimuli? Yes No

4. NEUROLOGICAL:

Seizures? Yes No Type: _____
Stroke? Yes No Location: _____
Tremors? Yes No
Traumatic Brain Injury? Yes No
Vertigo? Yes No
Tinnitus (ringing in the ears)? Yes No
Hearing loss? Yes No
Poor balance? Yes No

5. IMMUNE/ENDOCRINE/AUTONOMIC NERVOUS SYSTEM:

Immune deficiency? Yes No
Adrenal insufficiency? Yes No
Chronic Fatigue Syndrome? Yes No
Multiple Chemical Sensitivities? Yes No
Asthma? Yes No
Irregular Menstrual Periods? Yes No
Premenstrual Syndrome (PMS)? Yes No
Menopause? Yes No
Constipation? Yes No

Additional comments:

_____
_____
_____
_____
_____