National Holistic Institute – Client General Information

All information is held in strictest confidence. You may choose to skip answering any question you feel impinges on personal information you do not wish to disclose.

Name:_____ Date:_____

Date of Injury:_____ Referred by:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Telephone #:(_____)_____ Cellular #:(_____) _____

Email Address:_____

Date of Birth:_____

Occupation:_____

Employer:_____ Telephone: (_____)_____

Primary Physician:_____ Telephone : (_____)_____

Emergency Contact:_____ Phone:_____

Allergies:_____

Surgeries:_____

Medications:_____

History of Pathology

1. List areas of discomfort or pain_____
2. Describe onset of discomfort or pain_____

_____

3. Rate of pain today - please circle 1 2 3 4 5 6 7 8 9 10
   very little very painful
4. Frequency - please circle Constant Off/On At Rest With Activity
5. At what time of day is the pain at it's worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ During Sleep
6. Have you ever injured this area before? ☐ No ☐ Yes, PLEASE EXPLAIN AND INCLUDE DATES_____

_____

Continued on next page

7. Have you ever been in an accident (automobile, work related, falls, etc.)? ☐ No ☐ Yes, PLEASE EXPLAIN & INCLUDE DATES

_____

_____

_____

_____

_____

8. List all related treatments received for this injury:_____

_____

_____

9. Have you ever received a therapeutic massage for a specific problem or injury? ☐ Yes ☐ No

If yes, date of last massage_____

Was the treatment used effective_____

10. Is there anything that you do that creates, increases or decreases pain? ☐ No ☐ Yes, PLEASE EXPLAIN AND INCLUDE DATES

_____

_____

11. What are the physical duties required of your occupation?_____

12. What activities / hobbies do you enjoy?_____

13. List exercise and stress reduction activities: Include frequency_____

_____

14. In what position do you most often wake up? ☐ Back ☐ Side ☐ Stomach

15. Are you currently seeing any other healthcare professional? ☐ No ☐ Yes, if yes please list_____

_____

Please check any of the symptoms that apply to you and circle right or left when applicable:

HEAD:
- ☐ Neck
  - ☐ temples
  - ☐ forehead
  - ☐ top of head
  - ☐ in the eyes
  - ☐ entire head
  - ☐ base of skull
- ☐ Dizziness
- ☐ Fainting
- ☐ Light-headness
- ☐ Pain in ears
- ☐ Ringing in ears

NECK:
- ☐ Stiffness
- ☐ Pain at neck shoulder junction
- ☐ Pain when turning head
- ☐ Pain with side to side head movements
- ☐ Neck feels out of place
- ☐ Muscle spasm in neck
- ☐ Gliding/Grating sound with neck movement
- ☐ Diagnosed arthritic neck
- ☐ Diagnosed disc herniation What level?_____
- ☐ Diagnosed bone spurs

LOW BACK:
- ☐ Low back pain
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Diagnosed arthritis
- ☐ Diagnosed disc herniation what level?_____
- ☐ Pain up/down low back
- ☐ Pain across low back

MID BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder baldes
- ☐ Pain up/down back
- ☐ Pain across mid back
- ☐ Pain with breathing

ABDOMEN:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diagnosed irritable bowel/colitis

SHOULDERS:
- ☐ Pain in shoulder
  - ☐ Front
  - ☐ Back
  - ☐ Side
- ☐ Pain deep in shoulder joint
- ☐ Diagnosed bursitis
- ☐ Diagnosed Arthritis
- ☐ Can't raise arm
  - ☐ Above shoulder level
  - ☐ Over head

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in wrist
- ☐ Pain in fingers
- ☐ Sensation of pins and needles in arm
- ☐ Sensation of pins and needles in fingers
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Diagnosed arthritis
- ☐ Loss of grip strength

HIPS:
- ☐ Pain in buttocks
  - ☐ Standing
  - ☐ Sitting
- ☐ Pain on side of hip
- ☐ Pain deep in hip joint
- ☐ Pain on sit bone
- ☐ Diagnosed bursitis
- ☐ Diagnosed arthritis

LEGS AND FEET
- ☐ Pain down leg (R - L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pin & needles in legs (R-L)
- ☐ Numbness in leg (R - L)
- ☐ Numbness in feet (R - L)
- ☐ Numbness in toes
- ☐ Feet feel cold
- ☐ Cramps in feet (R - L)
- ☐ Swollen ankles (R - L)
- ☐ Swollen feet (R - L)
- ☐ Pain in foot (R - L)
- ☐ Pain in knee (R - L)
- ☐ Diagnosed arthritis

GENERAL
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel rundown
- ☐ Loss of sleep
- ☐ Loss of weight

Family History

☐ Check items that are known conditions **you** have

X Items that are known conditions among **family** members, and fill in relationship to you.

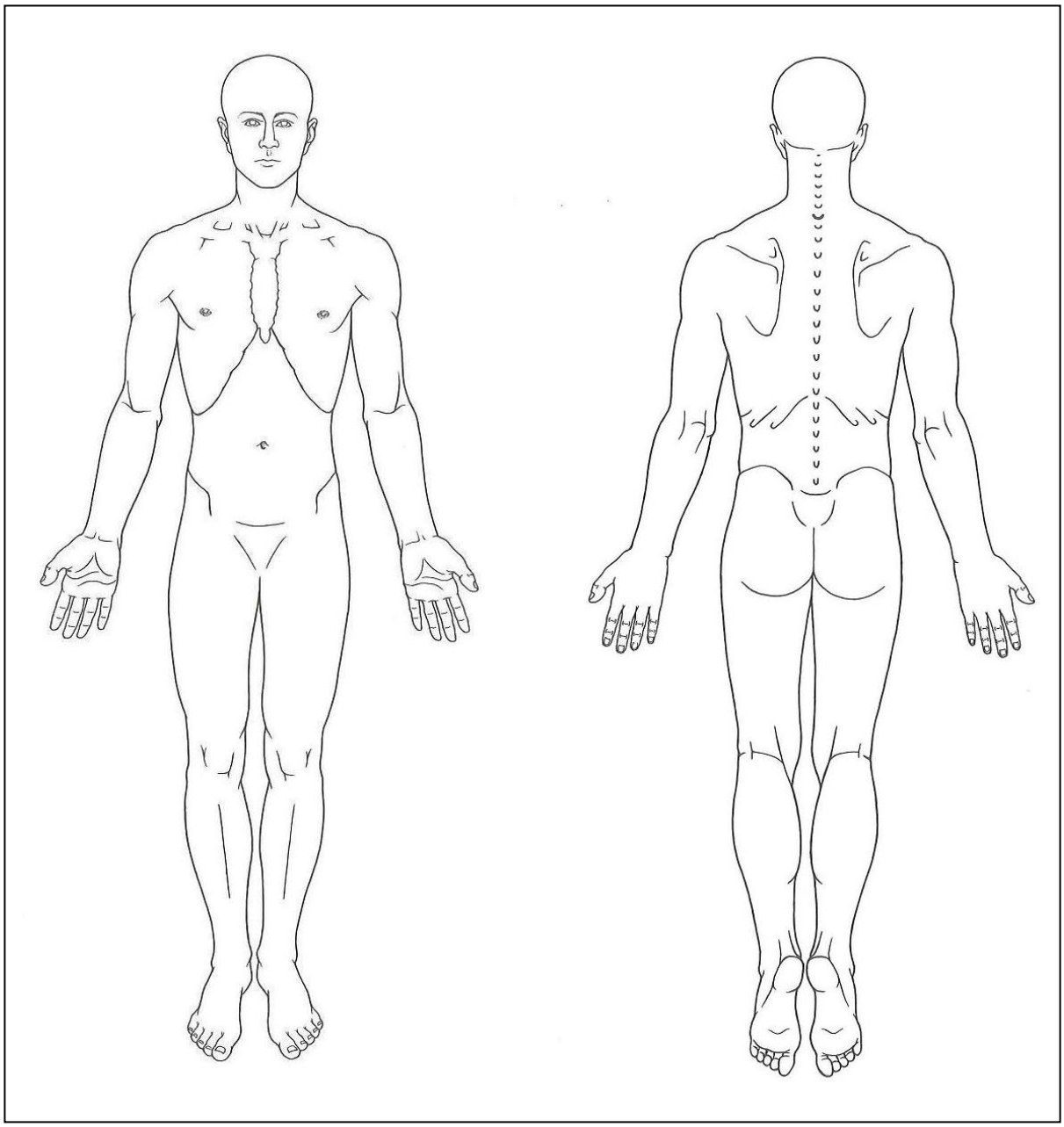
- ☐ Kidney
  Relation to You
  _____
- ☐ Anemia
  Relation to You
  _____
- ☐ Appendicitis
  Relation to You
  _____
- ☐ Cancer
  Relation to You
  _____
- ☐ Diabetes
  Relation to You
  _____
- ☐ Emphysema
  Relation to You
  _____
- ☐ Heart Disease
  Relation to You
  _____
- ☐ Miscarrige
  Relation to You
  _____
- ☐ Multiple Sclerosis
  Relation to You
  _____
- ☐ Stroke
  Relation to You
  _____
- ☐ Ulcer
  Relation to You
  _____
- ☐ Foot Problems
  Relation to You
  _____

Do you participate in any of the following:

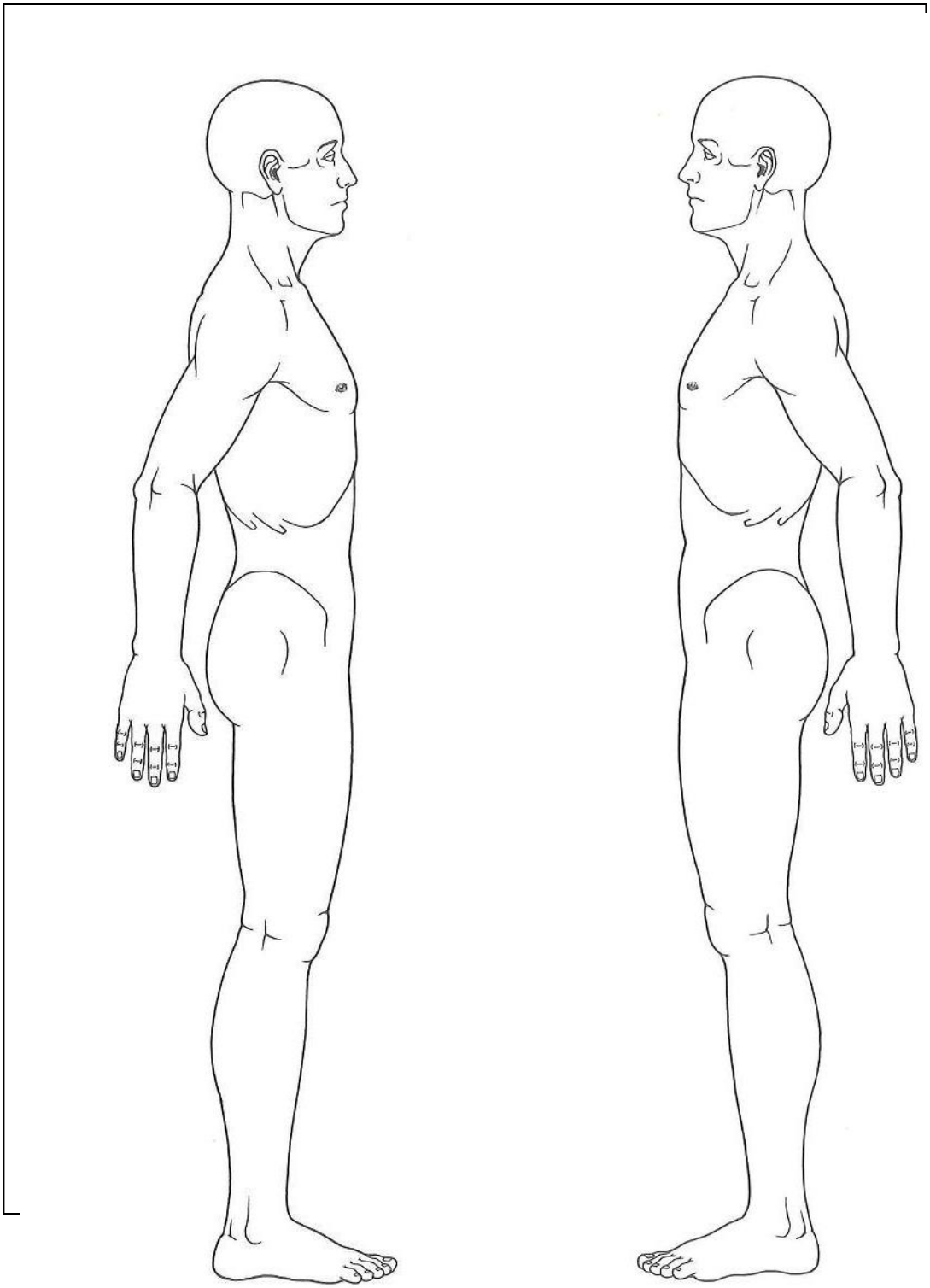
	Never	Sometimes	Always
Alcohol	☐	☐	☐
Coffee	☐	☐	☐
Tobacco	☐	☐	☐

Front/Back of Body

Please place an “X” on any area of pain or discomfort

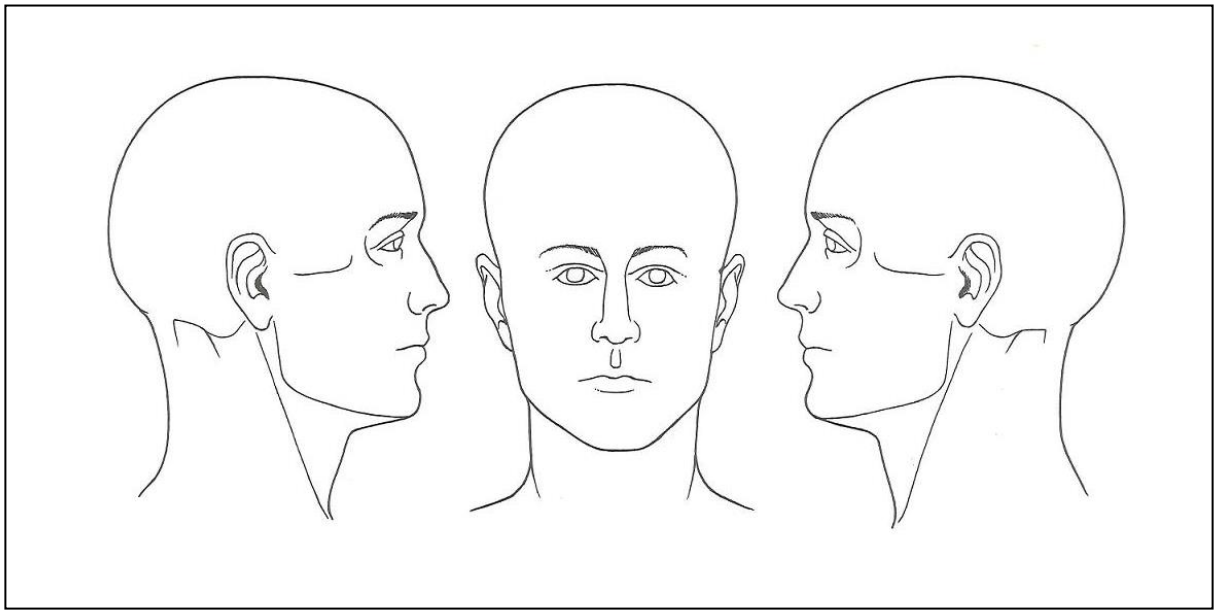


Right/Left of Body



Head/Neck

Please place an "X" on any area of pain or discomfort



Consent:

I understand that therapeutic massage therapists do not diagnose illness, disease, any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform joint mobilization.

I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for that service.

It is my choice to receive therapeutic massage as a form of therapy.

I understand that treatment given is designed to address the care and prevention of myofascial pain and dysfunction.

I have stated my pertinent medical conditions, and will update the massage therapist of any changes in my health status.

Permission to consult with your physician? ☐ Yes ☐ No

Signature: _____

Date: _____ Print Name: _____

National Holistic Institute – Health History Update

Name:_____ Date:_____

Circle One

1. Has there been any changes in your health or medical history since your last visit? YES NO

   What?_____

2. Are you currently taking any medication? YES NO

   What?_____

3. Has there been any injury to head, neck or back since your last visit? YES NO

   What?_____

4. Is there any condition or problem you wish to bring to the therapist's attention this visit? YES NO

   What?_____

Client Record Update

5. Is there a change in your address or phone number? YES NO

   What?_____

6. Is there a change in your work address or phone number? YES NO

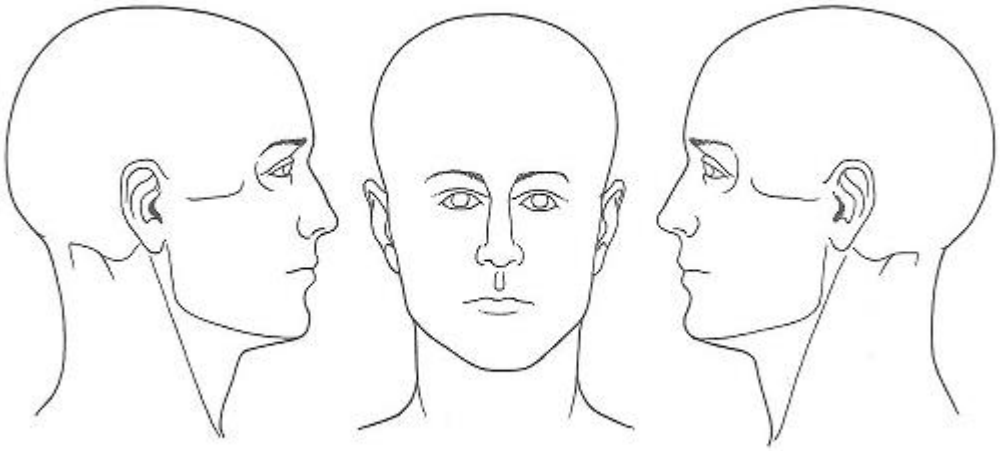
   What_____

Additional Comments:

_____

_____

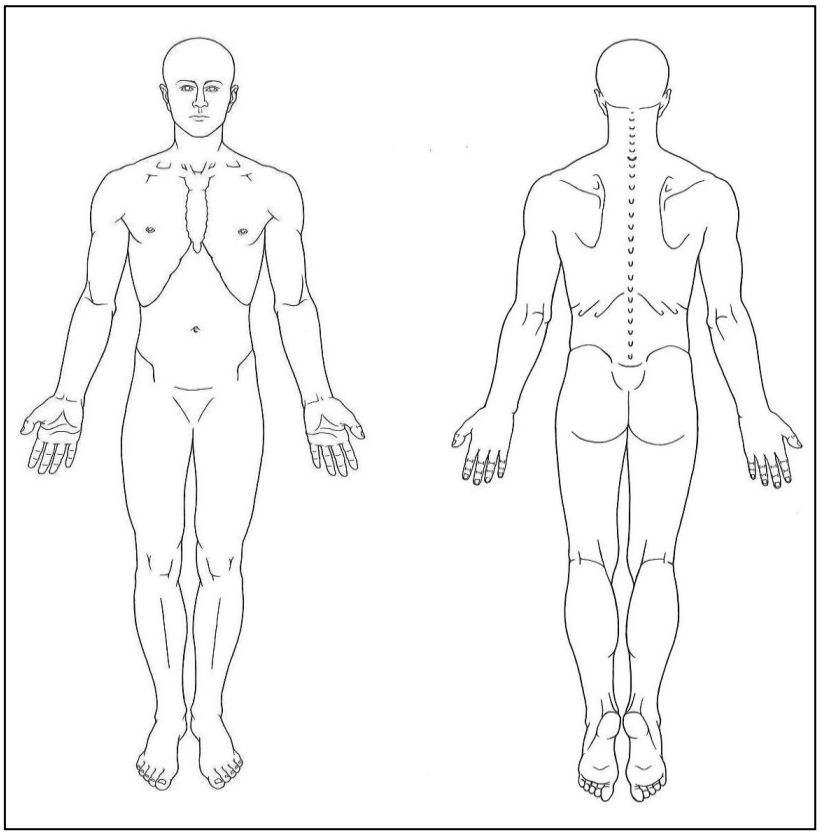
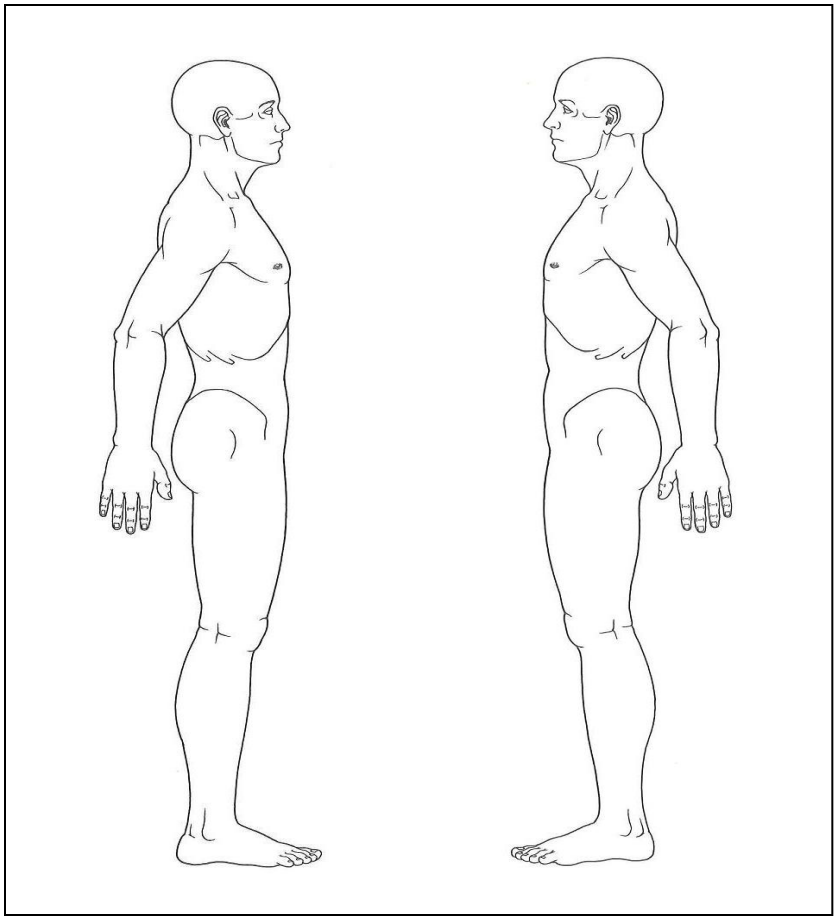
Head/Neck



Place an "X" to indicate location of pain or discomfort

Place an "X" to indicate location of pain or discomfort

Front/Back of Body



Right/Left Side of Body