Practitioner/Clinic Name: Heikewellnessmethod

Contact Information 505 500 7919

Health Information

Client Contact Information

Client Name: Date:

Date of Birth: Gender:

Address:

Phone: Email:

Referred by:

Emergency contact: Phone:

Physician/Health-care Provider name: Phone:

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.

Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

How recently?

What types of massage/bodywork do you prefer?

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

How do you feel today?

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No

Explain:

List the medications you currently take:

Are you wearing contacts? Yes ☐ No ☐

Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Practitioner/Clinic Name:

Health Information

Contact Information

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots, infections, congestive heart failure, contagious diseases, pitted edema
Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current	Past	Muscle or joint pain
Current	Past	Muscle or joint stiffness
Current	Past	Numbness or tingling
Current	Past	Swelling
Current	Past	Bruise easily
Current	Past	Sensitive to touch/pressure
Current	Past	High/Low blood pressure
Current	Past	Stroke, heart attack
Current	Past	Varicose veins
Current	Past	Shortness of breath, asthma
Current	Past	Cancer
Current	Past	Neurological (e.g. MS, Parkinson's, chronic pain)
Current	Past	Epilepsy, seizures
Current	Past	Headaches, Migraines
Current	Past	Dizziness, ringing in the ears
Current	Past	Digestive conditions (e.g. Crohn's, IBS)
Current	Past	Gas, bloating, constipation
Current	Past	Kidney disease, infection
Current	Past	Arthritis (rheumatoid, osteoarthritis)
Current	Past	Osteoporosis, degenerative spine/disk
Current	Past	Scoliosis
Current	Past	Broken bones
Current	Past	Allergies __
Current	Past	Diabetes
Current	Past	Endocrine/thyroid conditions
Current	Past	Depression, anxiety
Current	Past	Memory Loss, confusion, easily overwhelmed

Comments:

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: Date:

Parent or Guardian Signature (in case of a minor): Date: