Transformative Touch Tampa | Face & Body Studio
Barry Engh, BA, LMT
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CLIENT HISTORY FORM

Name:____Date:_____________________

Address:____Email:____________________________

City:____State:__________Zip:__________

Home Phone:____________________Work Phone:_________________Cell Phone:_________________

Height:_____Weight:______Age:_____ # of Children:______Occupation:_______________________________

Emergency contact:_____________________________Relationship:__________Phone #_____________

Who referred you to this office?____

Method of payment: (circle one)____cash____check______credit card *(MC, Visa, AMEX)*__________________

Who is responsible for payment (if not you)?____

* *

Are you taking a blood thinner? N Y – name:____
(PLEASE NOTE: we cannot do bodywork on you if you are taking prescription blood thinners – aspirin is not a problem! Blood thinner medication is <u>not</u> an issue for breathwork)

Describe major complaint:____

____

<u>When</u> and <u>how</u> did your condition develop?____

____

What makes your condition worse?____

____

List diagnosis (if known) and current treatment:____

_________________________________*(If available, please bring current reports: MRI, X-rays, Medical)*

Are you currently under doctor care? N Y – please explain:____________________________________

____

If auto accident, give date and description:____

____

Results from previous massage treatments:____

____

All surgeries & serious illnesses with approximate year:____

____

Dental work: <u>Dentures?</u> N Y – full___, partial___; <u>Implants:</u> N Y; <u>Bridge:</u> N Y – permanent____, removable____

Do you wear contact lenses? N Y Do you wear orthotics? N Y Facial surgeries? N Y ___________________

List **ALL** current medications and their purpose:____

____

(over please)

Do you have any skin disorders or allergies (i.e. latex)? N Y – please explain:_______________

____

Do you regularly drink caffeine beverages (coffee, tea, sodas, etc.) N Y – frequency_______________

Do you smoke? N Y – how much?_______________

Are you pregnant? N Y – estimated due date?_______________

Are you participating in a regular fitness program? N Y – please describe:_______________

____

Do you have any other medical condition or physical limitation that I need to know before you receive this bodywork?

N Y – please explain:_______________

Please circle any of the following that apply, present or past:

Fatigue	Severe Irritability	Neck Pain	Carpal Tunnel
Abdominal hernia	Severe Depression	Back Pain	Hand Numbness
Hiatal Hernia	Severe Menstrual Pain	Sciatic Pain	Hands Cold
Acid Reflux	PMS	Knee Pain	Shortness of Breath
Stomach Disorders	Edema	Feet Cold	Chest Pain
Constipation	Broken Bones	Foot Numbness	Heart Conditions
Diarrhea	Herniated Disc	Foot Pain	Low Blood Pressure
Arthritis	Headaches	Ears Ring	High Blood Pressure
Bursitis	Sinusitis	Shoulder Pain	Varicose Veins
Diabetes	TMJ	Arm / Elbow Pain	Blood Clots
Cancer	Dizziness	Loss of balance	Fainting Spells
Seizures	Scoliosis	Other: _______________	

I have listed ALL my known medical conditions, physical limitations, and medications. **I will inform my therapist of any changes in my physical health or medications.** I understand that a licensed massage therapist does not diagnose illness, disease, or any other medical, physical or psychological disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any problems that I have.

I agree to pay for all services at the time they are rendered, unless prior arrangements have been made.

<u>CANCELLATIONS and MISSED APPOINTMENTS:</u> Unless you are ill or have an emergency, we require 24 hr. notice for any schedule changes, or you may be responsible for the full session fee. We cannot do bodywork sessions if you are sick. If there is a question, please call.

I understand the information contained herein is privileged and confidential. I authorize the release of any information pertaining to my health to my attorney, insurance company, or referring physician / therapist.

<u>INSURANCE COVERAGE:</u> Our prescription form completed by your physician must be on file prior to treatment. I will give you the forms to file to your insurance company after payment has been made.

Signature:_______________Date:_______________

If client is a minor, signature of parent/guardian:_______________