Pathways to Health Client Information Form

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cell

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_home

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST:\_\_\_ Zip:\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_work

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can we correspond to the above address? (Please note that we do not share this information.) \_\_Yes \_\_No

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_ cancer | \_\_ diabetes | \_\_ infectious condition | \_\_ high blood pressure |
| \_\_ arthritis | \_\_ flu/ cold | \_\_ acute pain | \_\_ heart ailments |
| \_\_ fibromyalgia | \_\_ pregnancy | \_\_ edema (swelling) | \_\_ scoliosis |
| \_\_ bursitis | \_\_ recent injury | \_\_ osteoporosis | \_\_ epilepsy |
| \_\_ fever | \_\_ chronic pain | \_\_ chronic fatigue | \_\_ varicose veins |
| \_\_ bruise easily | \_\_ blood clots | \_\_ disc problems | \_\_ addictions/abuse |
| \_\_ headaches | \_\_ allergies | \_\_ emotional changes | \_\_ skin disorder |

Do any of the following apply to you? (Please check all that apply)

Please list any medications that you are presently taking:

Please list any surgical procedure(s) you've had:

Please list any broken bones or soft tissue injuries that you've had:

Please list your present symptoms and/or areas of discomfort:

In case of emergency, we should notify: NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find out about our service?

Given a gift certificate\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have completed this form to the best of my knowledge. I understand that bodywork is provided for the purpose of relaxation and relief of muscular tension. I understand that massage therapy or craniosacral therapy should not be construed as a substitute for medical examination, diagnosis or treatment. Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Marcus Walther from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).I understand that payment in full for my scheduled appointment is due upon completion of my session and I am responsible for such payment. Pathways to Health, LLC. is not responsible for the aggravation of any conditions which are not disclosed on this form. Please inform your therapist if you experience any discomfort (ie. pain, pressure, technique, room temperature, music, etc.) so that your experience with us is a positive one.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_