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

Profession:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, we should notify:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit:

Please describe why you are seeking treatment, symptoms, and what you hope to gain.

Health History: Please check all that apply and describe below.

Pain

\_\_Neck Pain \_\_Other Pain

\_\_Back Pain \_\_Muscle Spasms

\_\_TMJ Pain \_\_Inflamation

\_\_Headaches/Migraines \_\_Fibromyalgia

\_\_Stiff Joints \_\_Sciatica

\_\_Whiplash \_\_Tendonitis

\_\_Disc Problems \_\_Scoliosis

Other Conditions

\_\_High/Low Blood Pressure \_\_Diabetes

\_\_Heart Attack \_\_Cancer

\_\_Stroke \_\_Epilepsy/Seizures

\_\_Chronic Symptoms/Conditions \_\_Swelling

\_\_Chronic Fatigue Syndrome \_\_Arthritis

\_\_Digestive Problems \_\_Osteoporosis

\_\_Other Heart/Circulatory Conditions \_\_Fever

\_\_Flu/Cold \_\_Addictions

\_\_Blood Clots \_\_Skin Disorder

\_\_Varicose Veins \_\_Emotional Changes

\_\_Edema

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Sleep

Describe the quality of your sleep and sleeping difficulties.

Accident History

Please describe significant accidents and injuries, including when they happened, how you were affected and remaining symptoms.

Surgeries

Dental History

Braces, Dentures, Bite Guards or other treatments.

Medications

Please list medications you are currently taking including the reason for taking them.

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Other Treatments

What else have you done for your current condition/reason for visit (other types of health care, movement/exercise)?

Support & Resources

What type of support do you have in your life, and how do you resource yourself (i.e., where or to what do you turn in times of stress)?

What works well for you in life? (This can be anything, i.e., hobbies, relationships, jobs, there is no limit.)

I have completed this form to the best of my knowledge. I will continue to update this form and my therapist as my health and situation changes. By signing below, I hereby voluntarily consent to be treated with massage and/or craniosacral therapy from a licensed massage therapist. 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 the massage therapist practicing in the state of Virginia is not a primary care provider and that regular primary care by a licensed physician is an important choice that is strongly recommended by us.

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

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