Elevation Bodywork - Cassie Stonecash
Client Health History Form

Name_____ Phone ( ) _____ DOB _____/_____/_____
Address _____ City _____ State _____ Zip _____
Email _____
Occupation _____
Referred by _____
Emergency Contact #_____ Name/Relation _____

Have you experienced bodywork in the past? ____Yes ____No
If yes, what and how recently? _____

What are your bodywork goals? _____

My day is spent: ____ sitting in front of a computer ____on my feet ____ active

What type of hobbies and/or exercise do you partake in? _____
_____

Has your doctor given you any restrictions regarding exercise? ____Yes ____No
If yes, please explain _____

Do you have any chronic ongoing pain on a regular basis? _____Yes _____No
What activities cause this pain and/or make it worse: _____

Please take a moment to carefully read the following information. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided. Please mark any that apply to you:

_____ Sensitive to Touch or Pressure
_____ Hypermobility
_____ High/Low Blood Pressure
_____ Vision Problems
_____ Muscle/Tendon Injuries
_____ Tendonitis
_____ Bruise Easily
_____ Numbness/Tingling
_____ Scoliosis
_____ Headaches/Migraines
_____ Fatigue
_____ Depression
_____ Stress
_____ Sleep Difficulties
_____ Jaw Pain/Teeth Grinding
_____ Joint Swelling
_____ Issues getting up and down from the floor safely

_____ Disc Issues
_____ Sinus Problems
_____ Wearing Dentures
_____ Wearing Hearing Aids
_____ Wearing Contact Lenses
_____ Contagious Conditions
_____ Allergies
_____ Diabetes
_____ Lymphatic Condition
_____ Osteoporosis
_____ Blood Clots
_____ Cortisone shots
_____ Stroke
_____ Cancer
_____ Pregnant or may be pregnant
_____ Athlete's Foot
_____ Light-headedness, fainting, vertigo

_____ Artificial Joint(s)
_____ Breast implants
_____ Epilepsy
_____ Multiple Sclerosis
_____ Muscular Dystrophy
_____ Guillain Barre
_____ Varicose Veins
_____ Arthritis
_____ Rheumatoid Arthritis
_____ Lupus
_____ Fibromyalgia
_____ Pacemaker
_____ Osteoporosis medications
_____ Blood thinners
_____ Pain medications
_____ Recent antibiotics

If you answered “yes” to any of the above conditions, please explain if necessary:
_____
_____

Do you have any other medical condition, or are you taking any medications I should know about? ____Yes ____No.
If yes, please explain: _____
_____

Have you ever had any surgeries, accidents, or injuries? ____Yes ____No
If yes, please explain: _____
_____

Informed Consent for Bodywork

I understand that bodywork services are intended to be a therapeutic health aid. I further understand that bodywork does not take the place of a physician's care and is not a substitute for medical examination, diagnosis or treatment. I understand that 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 taken as such. Because 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 - to the best of my knowledge. I agree to keep the practitioner updated 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. Any information exchanged during a bodywork session is confidential and is only used to provide you with the best health care services.

If I experience any pain or discomfort during this session. I will immediately inform the practitioner so that the session may be adjusted to my level of comfort.

If I am not able to make a scheduled appointment, I agree to **cancel the appointment 24 hours in advance,** unless I have an emergency or illness within reason. In this case, I will call ASAP to reschedule or cancel my appointment. If I miss a scheduled appointment without giving 24 hours notice, **I agree to pay** the missed appointment charge of the cost of the appointment.

Client signature _____ Date_____

Consent to Treatment of a Minor: By my signature below, I hereby authorize _____ to administer bodywork therapy techniques to my child or dependent as they deem necessary.

Printed Guardian name _____ Date _____

Signature of Parent or Guardian _____