Vibrant Life Therapies

Client History

Name: ____ Date: ___________
Address:_____________________________ City: ____________________Zip:______
Phone: (1) _________________(2)_________________(3)_______________
Please indicate Home/Cell/Work May I leave messages? ____________
Email:______________________________________ Date of Birth: ___/___/______
Have you had a massage before? Y/N Please state the reason for your massage today: __________________________
____
Please list all areas of discomfort or limitations: ____
____
____
How would you describe your discomfort? ____
Intensity: (please circle) Mild Moderate Severe Other: ________________________________
Duration: (please circle) Constant Intermittent With certain motions: ______________________
When did you first notice pain or discomfort? ____
What activities are difficult or painful to do? ____
____
What activities are helpful to do? ____
____
Are currently under medical care for any reason? Y/N Please explain: ___________________________
____
Name of Physician: ______________________________ Phone: ___________________________
Have you ever been to a Chiropractor? Y/N If No, Would you be interested in a referral? Y/N
If yes, who and why? ____
____
List Medications (Both Rx *AND* OTC) and reason for taking them: ________________________________
____
____
____
____
List injuries: When: _________________ Injury Description: ____________________________
When: _________________ Injury Description:____________________________
When: _________________ Injury Description: ___________________________
List Surgeries: When:__________________ Description – Result of accident/injury? _______________
____
____
Have you had any lymph nodes removed? Y/N How many ________Location:___________________
What are your most frequent activities at work: Sitting Standing Lifting Twisting Computer
What are your most frequent activities at home: Sitting Standing Lifting Twisting Computer
Do you exercise regularly? Y/N Frequency: ___________ Type: ______________________________
Healthy Diet? Always Frequently Sometimes Rarely
Adequate Sleep (6-8 continuous hours)? Every Night 4-5 Nights 3 or less Difficulty sleeping Use sleep Aid
Sleep Position: Back Side Stomach Still Restless, many positions
Habits: Coffee/Tea Sugar/Soda Tobacco Alcohol How much water do you drink in a day? ________
In which part(s) of your body do you feel stress most often? (Circle all that apply): Head Neck Shoulders
Back Digestive Extremities Other: ____
Is a portion of your day set aside for relaxation? Y/N What kind? ___________________________

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Please check all that you have experienced:

___ Headache
___ Shooting Head pains
___ Sinus Problems
___ Loss of Smell
___Hay fever
___ Asthma
___ Loss of taste
___ Tightness of throat
___ Inflammation of throat
___ Thyroid problems
___ Face Flushed
___ Twitching of face
___ Loss of memory
___ Fatigue
___ Depression
___ Head feel too heavy
___ Dizziness
___ Fainting
___ Loss of balance
___ Ringing in ears
___ Wear glasses/contacts

___Muscle Spasms in the Neck
___ Grating in the Neck
___ Shoulder Tightness
___ Neuritis in shoulders/arms
___ Pins & needles in arms/hands
___ Cold Hands
___ Chest Pains
___ Shortness of breath
___ T.B.
___ Heart Pain
___ Heart Palpitations
___ Heart Attack
___ High Blood Pressure
___ Low Blood Pressure
___ Anemia
___ Rheumatic Fever
___ Nervous Stomach
___ Stomach trouble
___ Ulcers
___ Nerves/nervousness
___ Inner tension

___Cold Sweats
___ Liver problems
___ Gall bladder problems
___ Indigestion
___ Intestinal Gas
___ Constipation
___ Kidney problems
___ Bladder problems
___ Diabetes
___ Cancer
___ AIDS
___ Sleeping problems
___ Painful joints
___ Swollen joints
___ Arthritis
___ Slipped Disc
___ Pinched nerves in back
___ Pins & needles in legs
___ Swollen ankles
___ Cold Feet
___ Pains in legs/feet

Is there any other information you would like to share about yourself/your life situation? ___________________
____
____

Please read carefully:

As your massage therapist, I will not perform, diagnose, prescribe, or perform any other service which requires a license to practice. Please consult with a physician if you have any conditions which require attention. This therapy does not replace any medical care for any condition. It acts as an aid. It is your responsibility to notify me of any changes in your medicine intake and physical and/or medical condition.

It is understood by signing this form that it is medically safe for you to receive a massage and that it is your responsibility to provide immediate feedback regarding the amount of pressure applied to your body by me. Also by signing this form, you are releasing me from any liability surrounding the massage.

____ *Date:* __________________
Signature

Therapists Notes: