The Point Within: Bodywork by Carrie Coy

CLIENT INFORMATION AND CONSENT FORM

Date_____

Name_____

Home Phone_____Work/Cell Phone_____

Date of Birth_____Referred by_____

Occupation _____Email Address_____

Emergency Contact_____Phone_____

Have you received bodywork before? Y N If yes, how long since last session?_____

Do you have allergies to any oils, lotions or creams? Y N If so, what? _____

Please circle the degree of stress or fatigue to the following life areas:

Work 1 2 3 4 5 6 7 8 9 10

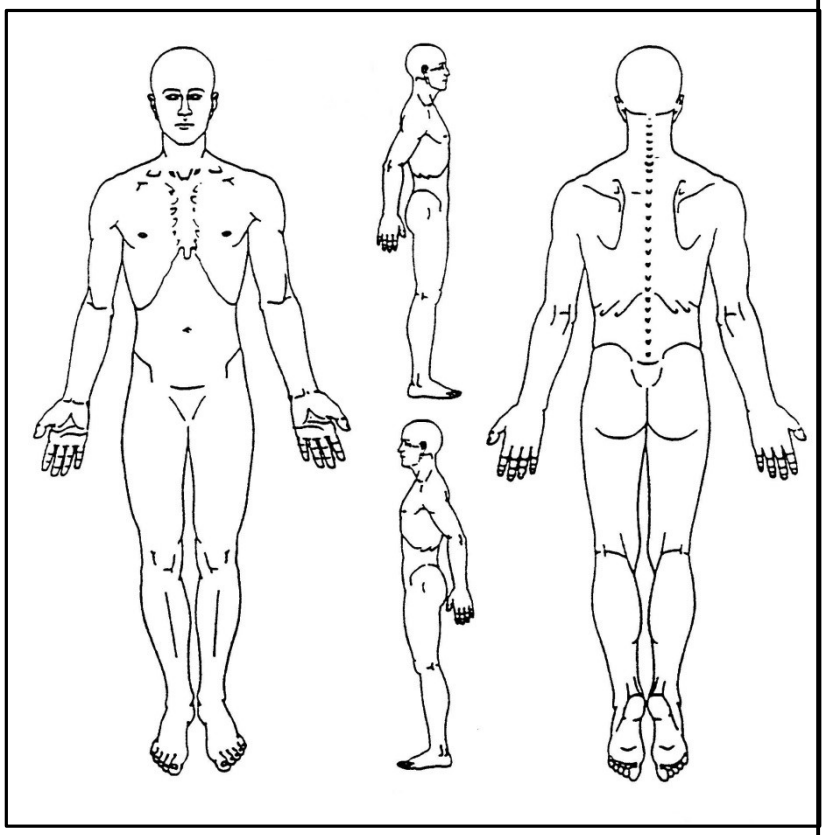
Mental 1 2 3 4 5 6 7 8 9 10

Physical 1 2 3 4 5 6 7 8 9 10

Social 1 2 3 4 5 6 7 8 9 10

Spiritual 1 2 3 4 5 6 7 8 9 10

Lifestyle 1 2 3 4 5 6 7 8 9 10



Symptoms affect sleep? Y N

Receiving medical treatment? Y N

Pregnant? Y N

Wearing contacts? Y N

Medications? Y N Please list below:

_____

_____

Your Goals for today's session: 1) _____

2) _____ 3)_____

Long Term Goals: 1)_____ 2) _____

Systems Review: Please indiciate if you have or have had conditions affecting the following systems of the body. Circle or give missing details, such as hx of cancer in any system.

☐ Skin (contagious, wound/burns, rashes, warts, infections, easy brusing)

_____

☐ Skeletal/joint (osteoporosis, arthritis, scoliosis, spinal/disc issues, fracture, bursitis, replacements)

_____

☐ Circulatory (blood clots, stroke, heart problems, high/low blood pressure, varicose veins, poor ciruculation) _____

_____

☐ Endocrine (diabetes, hyper/hypo thyroid, peri menopause, adrenal) _____

_____

☐ Respiratory (allergies, asthma, emphysema, bronchitis, chronic cough, deviated septum, apnea)

_____

☐ Digestive (abdominal pain, bowel discomfort, gastric reflux, food sensitivities, bloating) _____

_____

☐ Urinary (bladder issues, kidney dysfunction, kidney stones, frequent UTI's) _____

_____

☐ Reproductive (infertility, ectopic, hysterectomy, fibroids, miscarriage) _____

_____

☐ Neurological (migraines, epilepsy or narcolepsy, hx of trauma, RLS, cataplexy) _____

_____

Please list any major illnesses, surgeries or accidents that you have had. Include childhood.

Date_____ Details_____

Date_____ Details_____

Date_____ Details _____

I understand that massage and craniosacral is for enhancement of health and well-being and is not a substitute for medical treatment and diagnosis and that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I have stated all my known medical conditions and history and understand that it is my responsibility to keep Carrie Coy, LMT, CST, informed of any changes in my health and of any medications I may take in the future.

Signature _____ Date_____