History and Release

This history is confidential. The information will help determine if therapeutic bodywork is indicated and which procedures are appropriate.

Client Name:_____ Date of Birth:_____

Street Address: _____ Referred by: _____

City: _____ State: _____ Zip code:_____

Phone:_____ email address:_____

Emergency Contact: _____Relationship: _____Phone:_____

Occupation:_____

Please check all that apply:

___ Allergies – list below
___ Arthritis / Rheumatism
___ Asthma / Breathing Problems
___ Athlete's Foot/Fungal Infections
___ Back Pain (upper/mid/lower)
___ Birth Trauma
___ Blood clots/Phlebitis
___ Broken bones - list below
___ Bruise easily
___ Bursitis
___Cancer/tumors-list below
___Carpel Tunnel Syndrome
___ Chronic Fatigue
___ Contact Lenses
___ Dermatitis/Eczema
___ Diabetes
___ Digestive Problems/reflux/IBS
___ Disc probs (slipped,herniated, bulging)
___ Dizziness
___ Emphysema
___ Epilepsy / Seizure
___ Fibromyalgia
___ Chronic Headaches
___ Heart Disease Probs- list below
___ Hepatitis
___ High/low blood pressure
___ HIV/AIDS
___ Implants-list below
___ Infection/inflammation/fever
___ Kidney/bladder pressure
___ Lupus erythematosus
___ Lymphedema
___ Migraine headaches
___ Neck Pain
___ Orthopedic plates/pins
___ Plantar fasciitis
___ PMS / Menopause probs
___ Poor Circulation
___ Pregnant / Trying
___ Ringing in ears
___ Sciatic pain
___ Sinusitus
___ Skin rashes
___ Sprains/dislocations-list
___ Stiff Neck
___ Stress/anxiety/depression
___ Stroke
___ Surgeries-list below
___ Survivor of abuse/trauma
___ TMJ/Had braces on teeth
___ Ulcer/colitis/diverticulitis
___ Varicose Veins
___ Whiplash
___ Have received bodywork

Please explain checked items above:_____
_____

List Surgeries/hospitalizations and dates:_____
_____

List important injuries/accidents and dates:_____
_____

Any physical activities that cause you problems? _____
Any movements or positions that can relieve that pain? _____

Trouble lying in any position?_____

Medications/Supplements: (if additional space is needed, please attach a separate list)

Name:_____ Purpose:_____
Name:_____ Purpose:_____
Name:_____ Purpose:_____
Name:_____ Purpose:_____

Personal Health Assessment
Rate your level of overall health on a scale of 1-10 (10 is as healthy as you can imagine being):_____

Are you healthier than you were 5 years ago? Circle: Yes / No

If not, what has contributed to your decline in health?:_____
_____

What activities gives you feelings of energy/vitality? _____

What is your general goal for bodywork? _____

<u>Rights and Consent</u>
In therapeutic bodywork/massage, I understand that as a client I have the right to:

- Control the amount of pressure applied in any area of your body
- Have complete privacy while dressing and undressing
- Feel comfortable with the amount of clothing to be removed for the session, and the areas of your body to be touched
- Be draped at all times, except for the area being worked, and to feel secure in the draping technique being used
- Talk or not talk during the session, and to share or not share your internal experiences during the session
- Be listened to carefully, and treated with respect, verbally and nonverbally
- Terminate the session at any time

I agree to the following:

- That I understand that massage or 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. I will keep my therapist aware of any changes to my medical profile/condition, and I understand that there shall be no liability on the part of the therapist if I fail to do so. If my medical condition requires it, I understand that I may be required to receive clearance from a separate health care provider (e.g. physician) before receiving bodywork.
- **I understand that bodywork and massage therapy is not a substitute for medical examination, diagnosis or treatment.** I also understand that the bodywork I receive is for the basic purpose of relief of muscular tension, stimulation of the circulatory and lymphatic systems, craniosacral balance, and relaxation.
- I understand that licensed massage therapists are not physicians, physical therapists or chiropractors and that any information provided by them is for educational purposes only and should not be taken as medical advice, counseling or treatment. If I feel that I need medical examination, diagnosis or treatment, I will consult a physician or other health care practitioner.
- I consent to the bodywork offered by Rachel Bourke. I further understand that no results from the bodywork are or can be guaranteed (including pain relief or increased mobility).
- I understand that a practitioner's touch and the manner of communication between therapist and client are never intended to be sexual in nature. I agree to inform the therapist immediately if I feel the manner of touch or language feels sexual or inappropriate <u>to me</u> for any reason, so the session may be stopped or changed. I understand that any illicit or sexually suggestive remarks or advances

made by me, the client, are grounds for immediate termination of the session, and I, the client, will still be liable for payment of the full cost of the scheduled appointment.

- I will inform my therapist if, for any reason, touch in any area is uncomfortable for me, needs to be modified to be comfortable, or needs to be avoided for the current session (or any number of sessions). I will also inform my therapist of any changes to my mental or emotional state of being which may influence the choice of modalities/techniques to be used or the areas to be worked, for the purpose of enhancing my sense of safety, and my potential holistic benefits from the work.
- I will immediately inform the therapist if I experience any pain or discomfort during the session.

Client Signature:_____ Date:_____