

SURGICAL ALTERNATIVE

17886 N. US HWY 41
Lutz, FL 33549
MM27524

Institute of Alternative Therapy

Phone: 813-948-6300
fax 813-482-0766

CLIENT HISTORY FORM

Name: _____ Date: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Height: _____ Weight: _____ DOB: _____ # of Children: _____ Occupation: _____

Emergency contact: _____ Relationship: _____ Phone # _____

Who referred you to this office? _____

Method of payment: (circle one) cash check credit card (MC, Visa, AMEX)

Who is responsible for payment (if not you)? _____

* * * * *

Are you taking a blood thinner? N Y – name: _____

Describe major complaint: _____

When and how did your condition develop? _____

What makes your condition worse? _____

List diagnosis (if known) and current treatment: _____

(If available, please bring current reports: MRI, X-rays, Medical)

Are you currently under doctor care? N Y – please explain: _____

If auto accident, give date and description: _____

Results from previous massage treatments: _____

All surgeries & serious illnesses with approximate year: _____

Dental work: Dentures? N Y – full____, partial____; Implants: N Y; Bridge: N Y – permanent____, removable____

Do you wear contact lenses? N Y

List ALL current medications and their purpose: _____

(over please)

Do you have any skin disorders or allergies (i.e. latex)? N Y – please explain: _____

Do you regularly drink caffeine beverages (coffee, tea, sodas, etc.) N Y – frequency _____

Do you smoke? N Y – how much? _____

Are you pregnant? N Y – estimated due date? _____

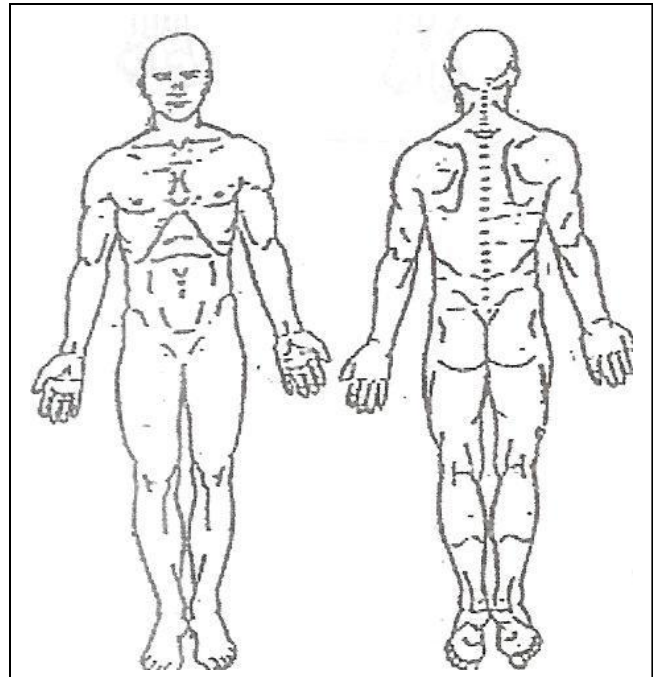
Are you participating in a regular fitness program? N Y – please describe: _____

Do you have any other medical condition or physical limitation that I need to know before you receive this bodywork?
N Y – please explain: _____

Please circle any of the following that apply, present or past:

Please shade in any areas of pain

- | | |
|-----------------------|-----------------------|
| AIDS (or HIV related) | Severe Irritability |
| Abdominal hernia | Severe Depression |
| Hiatal Hernia | Severe Menstrual Pain |
| Acid Reflux | PMS |
| Stomach Disorders | Fatigue |
| Constipation | Broken Bones |
| Diarrhea | Herniated Disc |
| Arthritis | Headaches |
| Bursitis | Sinusitis |
| Diabetes | TMJ |
| Cancer | Neck Pain |
| Shortness of Breath | Back Pain |
| Chest Pain | Sciatic Pain |
| Heart Conditions | Knee Pain |
| Low Blood Pressure | Feet Cold |
| High Blood Pressure | Foot Numbness |
| Varicose Veins | Foot Pain |
| Blood Clots | Shoulder Pain |
| Dizziness | Arm / Elbow Pain |
| Loss of balance | Carpal Tunnel |
| Fainting Spells | Hand Numbness |
| Ears Ring | Hands Cold |
| Edema | Scoliosis |



I have listed ALL my known medical conditions, physical limitations, and medications. **I will inform my therapist of any changes in my physical health or medications.** I understand that a licensed massage therapist does not diagnose illness, disease, or any other medical, physical or psychological disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any problems that I have.

I agree to pay for all services at the time they are rendered, unless prior arrangements have been made.

CANCELLATIONS and MISSED APPOINTMENTS: Unless you are ill or have an emergency, we require 24 hr. notice by phone (Monday – Friday) for any schedule changes, or you may be responsible for the full session fee (813-948-6300). We cannot do bodywork sessions if you are sick. Often we can do breathwork or cranial work as long as you are not contagious. If there is a question, please call.

I understand the information contained herein is privileged and confidential. I authorize the release of any information pertaining to my health to my attorney, insurance company, or referring physician / therapist. **INSURANCE COVERAGE:** Our prescription form completed by your physician must be on file prior to treatment. I accept some auto accident insurance, but all others will be filed by you after payment has been made.

Signature: _____ Date: _____

If client is a minor, signature of parent/guardian: _____