Practitioner/Clinic Name: P. Leilani Berry, LMP

Health Information

Contact Information: 206-914-3885
leilani@leilanimassage.com

Client Contact Information

Client Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Physician/Health-care Provider name: _____ Phone: _____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.

Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

_____

_____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No

Explain:

_____

_____

List the medications you currently take:

_____

_____

Are you wearing contacts? Yes ☐ No ☐

Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Practitioner/Clinic Name: _____

Contact Information: _____

Health Information

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots, infections, congestive heart failure, contagious diseases, pitted edema
Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current	Past	Muscle or joint pain _____
Current	Past	Muscle or joint stiffness _____
Current	Past	Numbness or tingling _____
Current	Past	Swelling _____
Current	Past	Bruise easily _____
Current	Past	Sensitive to touch/pressure _____
Current	Past	High/Low blood pressure _____
Current	Past	Stroke, heart attack _____
Current	Past	Varicose veins _____
Current	Past	Shortness of breath, asthma _____
Current	Past	Cancer _____
Current	Past	Neurological (e.g. MS, Parkinson's, chronic pain) _____
Current	Past	Epilepsy, seizures _____
Current	Past	Headaches, Migraines _____
Current	Past	Dizziness, ringing in the ears _____
Current	Past	Digestive conditions (e.g. Crohn's, IBS) _____
Current	Past	Gas, bloating, constipation _____
Current	Past	Kidney disease, infection _____
Current	Past	Arthritis (rheumatoid, osteoarthritis) _____
Current	Past	Osteoporosis, degenerative spine/disk _____
Current	Past	Scoliosis _____
Current	Past	Broken bones _____
Current	Past	Allergies _____
Current	Past	Diabetes _____
Current	Past	Endocrine/thyroid conditions _____
Current	Past	Depression, anxiety _____
Current	Past	Memory Loss, confusion, easily overwhelmed _____

Comments:

_____

_____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/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 construed as such. Because massage/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 agree to keep the practitioner updated as 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____