FULL CIRCLE **HEALTH HISTORY** Treatment by Kim Orte, LMP

This questionnaire has been designed to help me in providing the best professional care and service. The information contained herein will be kept in strict confidence. Thank you for taking the time to fill this out clearly. –Kim

Name _____ Nickname _____ Date _____

Address _____ Email _____

City, State and Zip Code _____

Day Phone ( ) _____ Eve Phone ( ) _____ Cell ( ) _____

Emergency Contact ( ) _____ What is your relationship to this person? _____

Date of Birth ____/ ____/ ____ Age _____ Referred by _____

Occupation _____

Do you wear ☐ a prosthetic device ☐ contacts ☐ dentures ☐ hair plugs or weaves

Primary health care professional's name and phone #. Check title _____

☐ MD ☐ Chiropractor ☐ Osteopath ☐ Nurse Practioner ☐ Naturopath ☐ Other _____

Are you involved in any other therapy at this time? ☐ yes ☐ no If yes, please describe and state how often _____

Are you currently taking any medications? ☐ yes ☐ no If yes, please list and describe for what _____

Do you currently have any known ☐ injuries ☐ bruises ☐ infections ☐ contagious diseases ☐ allergies

☐ Skin Problems. Please elaborate _____

Do you have any of the following ☐ HBP ☐ LBP ☐ known blood clots ☐ arthritis or bursitis

Are you pregnant? ☐ yes ☐ no If yes, how many months? _____

Please list any previous injuries, such as broken bones, severe sprains, sprains, whiplash, traumas, etc. Give dates:

Briefly describe any surgical operations you have had. Give dates: _____

Do you feel as though you "hold" stress or tension in any part of your body? ☐ yes ☐ no
If yes, is it ☐ occasional ☐ frequent.

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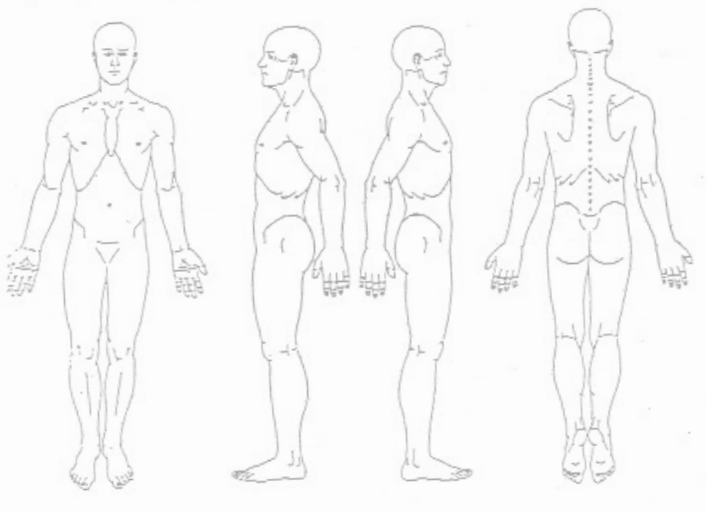
Do you experience any of the following

☐ chronic headaches ☐ chronic backaches

☐ bruxism (clenching, grinding of the teeth)

☐ tightness in the jaw (especially upon waking)

On the diagrams below, please circle those areas that best correspond to the places where you feel you hold stress, tension, or those areas where you may be currently experiencing discomfort or pain:



What type(s) of exercise do you do? How often?

How would you describe your dietary habits?

What do you currently do to relax, to relieve stress or tension?

Have you ever had bodywork/massage done before? If yes, for what reason?

If there is any other information you feel would be helpful to share with me, please share that at our sit-down together.

DURING THE MASSAGE TREATMENT

1. If you notice your self unconsciously holding your breath, simply release your breath through your mouth, this enables your muscles to relax. Exhaling releases tension, while holding your breath retains tension.

2. If Kim is applying pressure or stretching a muscle, again release your breath. Your muscles will relax more easily.

3. If at any time during the treatment anything is uncomfortable, please let Kim know so she can adjust the technique to your particular need.

4. It is your responsibility to communicate any questions or concerns to Kim regarding your treatment(s).

CANCELLATIONS & MISSED APPOINTMENTS

Circumstances might keep you from being at your scheduled appointment. I appreciate your immediate notification so that the space can be made available to another.

You will receive a reminder email 2 days prior to your appointment. Phone calls available upon request.

With less than 24 hours notice you will be charged a fee equal to 50% of the missed session. Emergency situations will be taken into consideration. Thank you.

It is my choice to receive massage therapy. I realize that the treatment given is for the well being of my body. This includes stress reduction, relief from muscular tension, spasms or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel my well being is being compromised.

I will uphold the above cancellation agreement.

I understand that massage practitioners do not diagnose illness, disease or any physical disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge massage therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated any and all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Signature Date