

**Ease, Joy & Alchemy LLC
New Client Information**

Therapist _____

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____ Birth Date _____

Family – Spouse/Partner, Kids, Creatures? _____

Email Address _____ May we add you to my mailing list? _____

Best Phone to Contact _____ Alternative Contact # _____

Emergency Contact – Name _____ Phone# _____

How did you learn about us? _____

If it was a personal referral, may we thank them for their referral? _____

Have you received Professional Massage Therapy or Bodywork before? _____

What Kinds? _____ How often? _____

Please check off any of the following conditions or symptoms which apply to you now or in the past:

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Muscle Sprain / Strain |
| <input type="checkbox"/> Contact Lens | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Heart Attack / Stroke |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Allergies (please list) | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Headaches - Migraines |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Skin Infections | <input type="checkbox"/> Constipation/Irregularity |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypo or Hyperglycemia | <input type="checkbox"/> Hormonal Changes |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Contagious Conditions | <input type="checkbox"/> Other Conditions |

Details for items checked above _____

Surgeries? _____

Are you currently experiencing any cold, flu-like, or other symptoms of infection? _____

Have you had any serious or chronic illness or traumatic accidents? _____

If yes, please give dates and details: _____

Please list and explain other conditions/symptoms you are or have experienced:

Pre-Natal Only: Due date _____ Current trimester _____

Do you have a history of cancer? _____ If any surgery, were any lymph nodes removed? _____
Do you have a history of radiation therapy? _____ Do you have a history of lymphedema? _____

Are you currently, or have you at any time within the last 12 months been under the care of a physician?
If yes, for what condition?

Are you on any medication? _____ If yes, which ones, and what are they prescribed for?

If appropriate, and with your knowledge, may I have permission to contact your Doctor / Therapist? _____
Doctor / Therapist Name: _____ Telephone _____

Do you support your health with other Complimentary and Alternative therapies?
Chiropractic___ Acupuncture___ Nutritional Counseling___ Naturopathic Physician___ Other _____

What forms of exercise to you enjoy regularly and how often ?

How much water do you drink each day? _____

What are you passionate about? _____

What goals do you have for this session? _____

Is there anything else that I should know about you to best provide therapeutic massage, lymphatic drainage and bodywork sessions for you?

I have completed this health form to the best of my knowledge. I understand that Massage Therapy and Bodywork, Lymphatic Drainage Therapy and CranioSacral Therapy services are a therapeutic health aid. They do not take the place of a physician's care when indicated.

Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an true emergency. In this case, I will call ASAP to reschedule my appointment. I understand that if I miss a scheduled appointment without giving 24 hour notice, I agree to pay the full appointment fee.

Signature _____ Date _____

Thank you for sharing this information, it is truly helpful.