Soul Alignment Healing

Brianna Anderson, RMT, CEP, LMT

Client Name: _____ Date: _____
Address:_____
_____
Phone: _____ E-mail: _____
DOB: _____ Age: _____ Occupation: _____
Emergency Contact: _____ Phone: _____
Spiritual Orientation: _____ Referred by: _____

What brings you in today? What are you hoping to experience or accomplish?
_____
_____

Massage Information

Is this massage medically necessary for a medical condition, injury, or surgery? _____
Have you ever received professional massage/bodywork before? _____
How recently? _____ How often? _____
What types of massage/bodywork do you prefer? _____
What kind of pressure do you prefer? Light Medium Firm

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? (sleeping, walking, exercise, work, childcare)? Yes No
Please explain:
_____
_____

Please list the medications that you currently take:
_____
_____

Are you wearing contact lenses?	Yes	No
Are you wearing dentures?	Yes	No
Are you wearing a hairpiece?	Yes	No
Are you pregnant?	Yes	No

Health History

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

_____

Please circle any of the following health conditions that you currently have:

Blood clots infections congestive heart failure contagious diseases pitted edema

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 (MS, Parkinson's, etc) _____
Current Past Epilepsy, Seizures _____
Current Past Headaches, Migraines _____
Current Past Dizziness, ringing in the Ears _____
Current Past Digestive Concerns (chron'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 Endocrine/Thyroid conditions _____
Current Past Depression, Anxiety _____
Current Past Memory Loss, confusion, easily overwhelmed _____

Consent for Treatment

If I experience any pain or discomfort during the 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 qualifies to perform spinal 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 of 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 (minor): _____ Date: _____