CLIENT INFORMATION FORM

Dominique Tardif, LMT 413 W. Idaho St., Ste. 202 Boise ID 83702

Today's date _____

Name _____ Date of Birth _____

Mailing Address _____

Street *City* *State* *ZIP*

Email Address _____

Phone : Mobile _____ Work _____ Home _____

Emergency Contact _____ Phone _____

Referred By: _____ May I thank them? Y / N

Occupation _____ How long? _____

Please indicate your current stress level : Low 1 2 3 4 5 High

What pain/issue prompted you to make this appointment?

_____

How long have you been experiencing this pain/issue?

_____

Are you currently receiving other treatments i.e. physical therapy, chiropractic, primary care physician, acupuncture, massage? Y / N

If yes, please explain _____

Issues/Events	**Type**	**Approximate Date**
Major illnesses?	_____	_____
Surgeries?	_____	_____
Injuries?	_____	_____
Accidents?	_____	_____
Concussions?	_____	_____
Major dental work/braces?	_____	_____

Please elaborate on any of the above

_____

_____

Are you taking any medications? Y N If yes, please explain:

_____

Do you exercise? Y / N / sometimes How often? _____

How many glasses of water do you consume daily? _____ Do you eat regular meals? Y / N / sometimes

How many hours is an average night's sleep? _____ I

How would you describe your sleep? (broken, fitful, solid, restful) _____

(0ver)

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/Fractured bones
Strains/Sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other:_____

Circulator/Respiratory

Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart condition
Allergies
Asthma
High blood pressure
Low blood pressure
Other:_____

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Crohn's Disease
Colitis
Other:_____

Nervous System

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Other:_____

Reproductive System

Pregnancy
Perimenopause
Menopause

Skin

Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophelia

Other

Anxiety
Depression
Difficulty concentrating
Hearing Impaired
Visually Impaired
Diabetes
Fibromyalgia
Post/Polio Syndrome
Cancer
Tuberculosis
Loss of Appetite
Other _____

I affirm that I have stated all of my known medical conditions and answered all questions truthfully. I will inform the health care provider of any changes in my status. I understand that bodywork should not be construed as a substitute for medical care, examination, treatment or diagnosis. I understand that a massage therapist licensed in the State of Idaho does not diagnose disease, illness, or prescribe any treatment or drugs, nor provide spinal manipulation.

Client's signature_____Date_____

Parent's signature for clients under 18 years of age _____