SERENITY THERAPEUTICS

Confidential Health Record

Please complete the front & back of this form.

Name:____Date:____________________

Address:____City:__________________ Postal Code:__________________

Work #:_____________________________Home #: ____________________________ Cell#:_________________________

E-Mail:____________________________Goals for your treatment?____

DOB (m/d/y):_______________Occupation:________________________________Company:___________________________

Massage Therapy Coverage Per Year?:_____________________________________Renewal Date:_______________________

Primary M.D.: ______________________Phone #:____________________Address:__________________________________

Place a checkmark in the gray areas below to the RIGHT of the conditions that you have or had. Otherwise leave it blank.

Cardiovascular:	Present	Past	**Other Conditions:**	Present	Past	**Females Only:**	Present	Past
High blood pressure			Constipation			Painful menstruation		
Low blood pressure			Liver_____________			Pregnant		
Poor circulation			Kidney___________			(Due ___/___/_____)		
Heart attack			Bladder___________			# of children_______		
Heart disease			Gall Bladder_______			Menopausal problems		
Phlebitis			Diabetes (onset)			_________________		
Stroke			_________________					
Vericose veins			Sinus problems (type)			**Infections:**		
			_________________			Hepatitis		
Respiratory:			Insomnia			Tuberculosis		
Smoking			Epilepsy			HIV/AIDS		
Chronic cough			Osteoporosis			Herpes		
Shortness of breath			Cancer (type)			Planters warts		
Bronchitis			_________________			Other_____________		
Asthma			Arthritis (type)					
Emphysema			_________________			**Stiffness/Pain:**		
Other breathing						Neck		
Problems/allergies (type)			**Head/Neck:**			Upper back		
_________________			Headaches			Mid back		
			Vision problems			Lower back		
Skin:			Vision loss			Shoulders (L/R)		
Skin conditions/allergies/			Contact lenses			Legs (L/R)		
Loss of sensation			Ear problems (type)			Knees (L/R)		
___________________			_________________			Other____________		
			Hearing loss			_________________		

Exercise routines?:____

____Frequency? __________________

Other Health Care Activities? Please circle the following that you are currently receiving and underline those you've had in the past:

Chiropractic Physiotherapy Acupuncture Naturopathy Homeopathy Yoga Pilates Shiatsu Rolfing

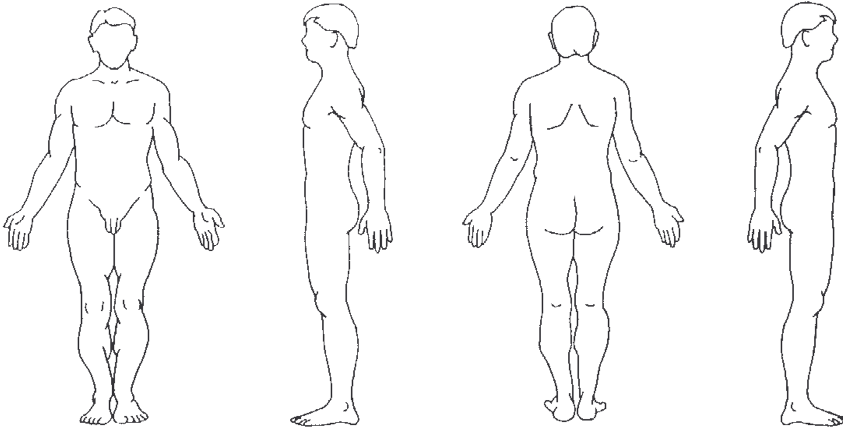
Craniosacral Massage Therapy Thai Massage Osteopathy Colonics Tai Chi Reflexology Psychotherapy

Other____

____

Medication Name:	Condition It Treats:	Surgery/Injury:	Date:
1.___		1.___	
2.___		2.___	
3.___		3.___	
4.___		4.___	
5.___		5.	
6.___		Other medical conditions:___	
7.___		___	
8.___			
9.___		Internal pins, wires, artificial joints, etc.___	
10.___		___	
11.			

Please circle on the body diagram below where you feel pain or discomfort.



Between one and ten, what number would you choose for your current pain or discomfort? Please circle below.

No pain/Full function 0 1 2 3 4 5 6 7 8 9 10 Extreme pain/No function

CONSENT TO TREATMENT

I understand that massage therapy involves manipulating the soft tissues and joints of the body in order to develop, maintain, rehabilitate or improve physical function and relieve pain. During the massage treatment I will remain respectfully draped (Swedish & Hot Stone) or clothed (Thai Massage), with comfort, security and privacy in mind.

I understand that during the course of the treatment, the massage therapist will be open to any questions about procedure or effects. I understand the whole external body, excluding private areas, may be massaged.

I further understand that at any time before or during treatment, the therapist will respect my communication that I not be touched in any particular area of the body, or that I wish to stop or modify treatment for any reason.

All information exchanged between myself and the therapist is confidential and requires my consent for release unless the therapist is legally obligated to disclose information.

I understand that my accurate and up to date health history is imperative to ensure a safe and effective treatment, and that I must notify the massage therapist as soon as any information changes.

I hereby consent to massage therapy as discussed between myself and the therapist, and agree that the given health history information is complete and accurate.

A MISSED APPOINTMENT WITHOUT AT LEAST 24 HOURS NOTICE OF CANCELLATION WILL BE BILLED TO MY ACCOUNT. IF I ARRIVE LATE FOR AN APPOINTMENT, I WILL PAY THE FULL SESSION FEE, AND THE APPOINTMENT WILL END AT THE SCHEDULED TIME.

Date________________________Signature____