massagology

for therapy. for health. for you.

Comprehensive Health Information Form

(please print legibly)

Today's date _____

Name _____

Address _____

City, State, Zip _____

How long have you lived at your current address? _____

Phone (mobile) _____ (home) _____

(work) _____ May I text you about appointments? Y N (NO SPAM!)

E-mail _____

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Whom do I contact in case of emergency? _____

Relationship to you _____

Fastest method(s) of contact _____

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What is the purpose of your visit? Aromatherapy Myofascial Release Both

If you have signed-up for one treatment and may consider adding the other, please fill out ALL sections

Please let me know your intention (what you wish to accomplish). _____

_____

_____

_____

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Occupation _____

Hobbies/Activities _____

_____

What is your relationship status? _____

Child(ren)? Y N How many? _____

How many people and/or animals live in your home? _____

What are their relationships to you? _____

_____

What is your Date of Birth? _____

Location and Time of your birth? _____

Height _____ Weight _____

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Please list any Rx Medications, OTC medications, nutritional supplements, vitamins, minerals, etc that you take? _____

_____

_____

_____

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Women Only - Are you Pregnant? Y N If so, how far along? _____

How many times have you been pregnant? _____

If you have (a) child(ren), how would you describe the(ir) birth(s)? _____

_____

_____
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In what position do you normally sleep? _____

On average, how many hours of sleep do get each night? _____

Do you have difficulty falling asleep? Y Mostly Sometimes Rarely N

Do you have difficulty staying asleep? Y Mostly Sometimes Rarely N

Do you sleep soundly? Y Mostly Sometimes Rarely N

Do you feel well-rested in the morning? Y Mostly Sometimes Rarely N

Do you dream? Y Mostly Sometimes Rarely N

Nightmares? Y Mostly Sometimes Rarely N

Recurring Dreams? Y Mostly Sometimes Rarely N

Lucid Dreams? Y Mostly Sometimes Rarely N

Please explain any answers that need further clarification _____

_____

_____

_____

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Please mark any of the following that pertain to you. Please use the empty space to explain any of your answers.

C = Current condition (have symptoms now or within past several weeks)
R = Recent condition (within past 5-7 years, but no current symptoms)
X = Past condition (more than 7 years ago)
F = If it pertains to (a) close family member(s) (Some may have two marks if both you and family member(s) are/were affected)
Leave blank if it does not or never has pertained to you or to a close family member.

_____ Headaches/Migraines

_____ Pain

_____ Fatigue

_____ Sinus

_____ Allergies

_____ Cancer

_____ Diabetes

_____ Autoimmune Disorders

_____ Cardiovascular Disease

_____ ADD/ADHD

_____ Anxiety

_____ Depression

_____ Trauma/PTSD

_____ Constant Feelings of Stress

_____ Butterflies in Stomach

_____ Bipolar

_____ Nervousness

_____ Mood Swings

_____ Difficulty Concentrating

_____ Memory Loss

_____ Panic Attacks

_____ Seasonal Affective Disorder

_____ Alcohol (how much/often?)

_____ Tobacco (how much/often?)

_____ Coffee/Tea (how much/often?)

_____ Soda (how much/often?)

_____ "Illegal" substances (how much/often?)

_____ Chemical sensitivities

_____ Bloating

_____ Chronic Fatigue

_____ Fibromyalgia

_____ Hepatitis (A B C ?)

_____ Hepatic Disease (explain)

_____ Cirrhosis

_____ Arthritis (Osteoarthritis or Rheumatoid Arthritis?)

_____ Blood Pressure (High? Low?)

_____ Catch Everything Going Around

_____ Sore Throat

_____ Common Cold

_____ Influenza

_____ Ear Aches

_____ Excessive Ear Wax

_____ Ear infections

_____ Dizziness/Vertigo

_____ Fainting/Blackouts

_____ Cavities/Fillings

_____ Periodontal Disease

_____ Dry Mouth

_____ Excess Saliva

_____ Difficulty Swallowing

_____ Lupus

_____ Multiple Sclerosis

_____ Neuropathy (What kind?)

_____ Parkinson's

_____ Seizure Disorders

_____ Numbness/Tingling/Shooting Pain/Dull Ache (where?)

_____ Sciatica

_____ IBS

_____ Constipation

_____ Diarrhea

_____ Diverticulosis/Diverticulitis

_____ Abdominal Pain

_____ Ulcers

_____ Eating Disorder (Which one(s)?)

_____ Loss of Appetite

_____ Increased Appetite

_____ Nausea

_____ Heartburn

_____ Pain After Eating

_____ Parasites (explain)

_____ Kidney function

_____ Incontinence

_____ Difficulty emptying the bladder

_____ Rashes/Boils/Cysts (where?)

_____ Acne

_____ Dry Skin and/or Hair

_____ Oily Skin and/or Hair

_____ Scars/Moles/Skin Tags

_____ Bruise Easily

_____ Hair Loss

_____ Impetigo

_____ Psoriasis (trigger(s)?)

_____ Eczema

_____ Fungal Infections

_____ Dry and/or Cracked Heels/Feet

_____ Asthma

_____ Chicken Pox/Shingles

_____ Autism Spectrum Disorders

_____ Scoliosis

_____ TMJ Dysfunction

_____ Carpal Tunnel

_____ Thoracic Outlet

_____ Plantar Fasciitis

_____ Restricted Hip Mobility

_____ Knee Pain

_____ Tendonitis/Bursitis

_____ Cramps/Spasms

_____ Muscle Soreness

_____ Stiffness (where?)

_____ Limited Range of Motion (where?)

_____ Frozen Shoulder

_____ Neck/Upper Back Pain

_____ Mid-Back Pain

_____ Low Back Pain

_____ Chest Pain

_____ Blood Clots

_____ Varicose/Spider Veins

_____ Stroke

_____ Aneurism

_____ Swollen Ankles

_____ Shortness of Breath

_____ COPD

_____ Emphysema

_____ Hay Fever

_____ Tightness in Chest

_____ Difficulty Breathing In

_____ Difficulty Breathing Out

_____ Runny/Stuffy Nose

_____ Sneezing

_____ Laryngitis

_____ Dry or Wet Cough

_____ Difficulty Smelling

_____ Difficulty Tasting

_____ Painful Menstruation

_____ Irregular Menstrual Cycles (please explain)

_____ Dysplasia

_____ HPV

_____ Endometriosis

_____ Painful Intercourse

_____ Vaginal Discharge

_____ Vaginal Dryness

_____ Fibrotic Cysts

_____ Polycystic Ovaries

_____ Problems with Menopause/Peri-menopause

_____ Low Libido

_____ Enlarged Prostate, Nodules, Lumps, Polyps

_____ Erectile Dysfunction and/or Impotence

_____ Testicular Issues

_____ Tender and/or Lumpy Breasts

_____ Clogged Milk Ducts

_____ Mastitis

_____ Irregular Sleep

_____ Hot Flashes

_____ Night Sweats

_____ Think a Lot

_____ Worry

_____ Daydreamer

_____ Happy

_____ Nervous

_____ Sad

_____ Overweight

_____ Underweight

_____ Sudden Change in Weight (explain)

_____ Obesity

_____ Lethargic

_____ Hashimoto's Thyroiditis

_____ Hypothyroidism

_____ Hyperthyroid (Grave's Disease)

_____ Adrenal Fatigue

_____ Hyperglycemia

_____ Hypoglycemia

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Accidents/Injuries. Please include date(s), injury, and a description of what happened as best you can recall. Also include the treatment(s) you received afterwards.

Do you feel like any of these accidents/injuries are feeding into your current issue(s)?

Hospitalizations/Surgeries. Please include date(s), problem(s) being treated, and a description of the treatment you received as best you can recall. What kind of follow-up did you receive?

Do you feel like any of these hospitalizations/surgeries are feeding into your current issue(s)?
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Do you have any pins, screws, mesh, ports, microchips, pacemakers, joint replacements, or other hardware in your body? Please explain. _____

_____

~~~ This section optional for "Myofascial Release only" clients ~~~

What are your favorite foods? _____

_____

What are your least favorite foods? _____

_____

What time(s) of day do you generally eat your meals? _____

_____

_____

Do you have any dietary restrictions (food allergies, gluten free, vegetarian, vegan, lactose intolerant, etc.)? _____

_____

_____

Are you sensitive to any foods? _____

_____

How would you describe your relationship with food? _____

_____

_____

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Do you exercise? Y N

If so, what/how often? _____

_____

_____

Do you enjoy your current exercise regimen? Y N (Please explain) _____

_____

_____

~~~ This section optional for "Myofascial Release only" clients ~~~

Do you anger or become irritated easily? _____

What do you find most rewarding about your job? _____

_____

What do you find least satisfying about your job? _____

_____

Are you moody and emotional? _____

Explain any experience you feel is relevant to your emotional and/or psychological health.

Include family history and relationship(s) to parents/family members/friends/etc. _____

_____

_____

_____

Describe your home life. _____

_____

_____

How do you de-stress? _____

_____

_____

What are your strengths? _____

_____

What are your weaknesses? _____

_____

Do you have a partner? Y N

How would you describe your relationship? _____

_____

_____

How do you feel about your personal relationships with friends/co-workers/etc? _____

_____

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_____
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How are you affected by political issues? _____

_____

How are you affected by environmental issues? _____

_____

How are you affected by lifestyles and living conditions around the world? _____

_____

Do you have a religious or spiritual practice? Please include anything you believe inspires your non-physical existence (weekly services, yoga, tai chi, meditation, prayer, the 'zone' during exercise, etc…). _____

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Do you wear corrective lenses? Y N

What is your diagnosis? Nearsighted? Farsighted? Etc? _____

_____

Does your eyesight change often? Y N Please explain. _____

_____

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How is your hearing? _____

Has it changed over the years? Y N Please explain. _____

_____

Do you experience tones, tinnitus/ringing in your ears? Y N Please explain. _____

_____

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How would you describe your sense of smell? _____

_____
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What odors do you like? _____

_____

What foods do you like to smell? _____

_____

What is your favorite scent? _____

Do you like perfumes/colognes? Y N _____

How do you like your home to smell? _____

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Please take some time to share any other concerns you wish to share and include anything you feel is important that may have been missed. _____

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Massagology, LLC

Myofascial Release Consent Form

I understand that Massagology LLC requires 48-hours notice (excluding weekends) for any cancellations or changes to my scheduled appointment. I understand that if I fail to do so, I am responsible for the full amount of the service. I understand that payment must be received, in full, before my next appointment with Massagology, LLC. I also understand that if I arrive late for my appointment, I will receive the remainder of my time but will be responsible for payment in full.

Initials _____

I understand that Myofascial Release (MFR) is a technique that can help reduce muscle tension, pain, and/or restricted range of motion. MFR can also release emotional tension. It can be a stressful process when restrictions are released in the body and the mind is released from the pressures of dealing with the dysfunction cause by those restrictions. I understand that my emotions are a natural response and an important part of the healing process. I understand that discomfort or soreness during or after a session may occur. I will communicate with the therapist during the session as to what I am feeling.

Initials _____

I am aware that MFR is contraindicated for some medical conditions, and I affirm that I have answered all questions truthfully and to the best of my knowledge. I agree to update the therapist on any changes in my health status and medical history; and I understand that there shall be no liability on the therapist's part should I neglect to do so. I agree to inform the therapist of any discomfort experienced during my sessions, and furthermore understand that I have the right to refuse any treatment at any time. I understand that I have the right to ask that a technique be modified in regard to pressure or modality. I have the right to ask questions to fully understand my care. I understand that I may experience a temporary increase in pain and soreness as a result of treatment techniques. I understand that MFR techniques may cause emotional releases. I am willing to consult my doctor if advised to do so.

Initials _____

I understand that MFR is not a substitute for medical examination or diagnosis and that I should see a health care provider to address healthcare concerns that I may have. There may be times when basic stretches, exercises, or self-treatment techniques are recommended by the therapist, and I acknowledge that these are simply recommendations. It is my responsibility to contact a healthcare provider before taking part in any stretching, exercise, or self-treatment regimen that is recommended for me.

Initials _____

I understand that I am responsible for payment at the time of service. I understand that Massagology LLC does not accept insurance, Medicaid, or BWC. I understand that Massagology LLC does not bill insurance, Medicaid, or BWC. Any requests or requirements for Massagology LLC to handle insurance, Medicaid, or BWC paperwork, phone calls, or other correspondence will be billed to me at the normal hourly rate and rounded-up to the nearest quarter-hour.

Initials _____

I have read, understand, and agree to all of the above statements.

Print name _____

Signature _____

Today's Date _____

Massagology, LLC

Aromatherapy Consent Form

I understand that aromatherapy consultation is designed to gather information so that my practitioner is able to design and create aromatic products based upon my unique needs and intentions. I understand that my aromatherapist at Massagology LLC does not diagnose, prevent or treat any illness, disease, or any other physical or mental condition. I understand that this is not a substitute for medical treatments and it is recommended that I see a qualified professional for any physical or mental condition that I may have. This consultation does not take the place of a medical evaluation. I understand that aromatherapy can help me stay healthy, function normally, and contribute to my well-being

Initials _____

I have read the above information and I hereby give my permission to Massagology LLC to design an aromatic program for me based upon my unique needs and intentions. I understand that essential oils and aromatherapy is a complementary holistic therapy and not intended to treat, diagnose, and/or cure any medical issues. I affirm that I have answered all questions accurately and honestly. And realize the importance of notifying the practitioner of any changes that may affect my health profile and understand that there shall be no liability on the practitioner's part should I neglect to do so.

Initials _____

I know that I need to seek medical attention by a proper qualified health professional when appropriate. I understand that all my information is strictly confidential and maintained at all times. Upon request I may give my permission to the practitioner to use my information in a case study and may request a copy of the case study if so desired. I understand and appreciate the practitioner's dedication to using the highest quality, therapeutic grade essential oils.

Initials _____

I understand that Massagology LLC requires 48-hours notice (excluding weekends) for any cancellations or changes to my scheduled consultation. I understand that if I fail to do so, I am responsible for the full amount of the service. I understand that payment must be received, in full, before my next consultation with Massagology, LLC. I also understand that if I arrive late for my consultation, I will receive the remainder of my time but will be responsible for payment in full.

Initials _____

I have read, understand, and agree to all of the above statements.

Print name _____

Signature _____

Today's Date _____