# Tree Frog Massage Therapy

Deborah Van Leer RMT, DipCOT www.treefrogmassage.com

---

## Client Intake & Health History Form—Bowen Therapy

An accurate health history ensures that it is safe for you to receive a treatment, helping your therapist determine a proper treatment plan. If and when your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

**Personal Information**

Name: ______________________________________________
Address: ____________________ _____________________________________________Post Code: ________
Home Phone: ____________________Cell: ___________________ Occupation: ______________________
Date of Birth: ________________Email: ____________________________________________________
Doctor: ___________________________________Phone: _______________ May I contact? Yes No
Emergency Contact Name: ______________________________Phone: ____________

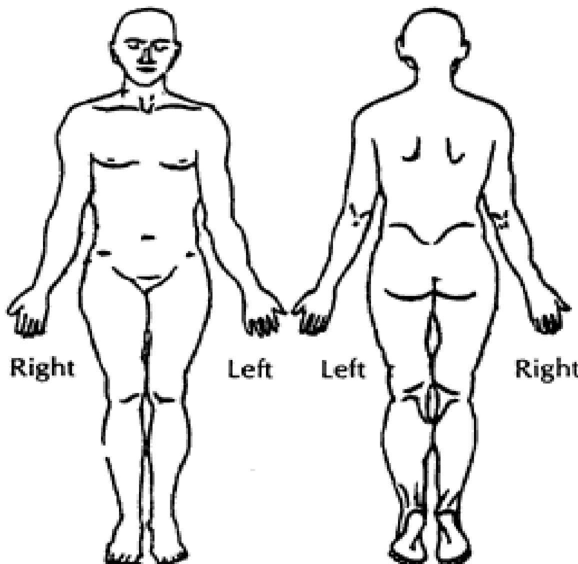
Have you had Bowen Therapy before? Yes No
Reason? ________________________

Are you currently taking any medications? Yes No
If yes, please list name and reason for
medications_______________________________________________________________________________

Are you currently seeing a healthcare professional? Yes No
If yes, please list names and reason/treatment :
_____________________________________________________________________________________

Have you taken any anti inflammatory medication, pain killers, muscle relaxants or mood altering medication within the past 24 hours? Yes No
If Yes, what and how much?________________________________

Indicate with an (X), if any, the areas in which you are feeling discomfort:




**Primary Complaint:**

**When, how did it begin?**

**What aggravates the condition?**

**What relieves the condition?**

**Limitations caused by condition?**

Do you do regular exercise? Yes No Type: __________________________ Frequency: ____________________
Leisure Activities:_____________________________________________________________________________

Do you eat a balanced diet? Do you take any dietary supplements?

Is your energy level: High Average Low Do you suffer from stress? Yes No

Please indicate all conditions you have experienced. Mark with an * if there is a family history.

**Joint/Soft Tissue Discomfort:**
__ Arms
__ Upper Back
__ Mid Back
__ Lower Back
__ Degenerative Discs
__ Feet
__ Hands
__ Hips
__ Jaw
__ Knees
__ Legs
__ Neck
__ Osteo Arthritis
__ Rheumatoid Arthritis
__ Sciatica

**Skin:**
__Rashes
__Itching
__Bruise Easily
__Dryness
__Boils

Other _________________

**Headaches:**
__ Tension
Frequency?
__ Migraines
Frequency?

**Infectious:**
__ Hepatitis
__ Tuberculosis
__ Human Immunodeficiency Virus(HIV)
__ Herpes
__ Cold
__ Flu
__ Athlete's Foot
__ Warts

**Limitation of Movement:**
__ Neck
__ Shoulders
__ Elbows
__ Wrists
__ Hands
__ Low back
__ Hips
__ Knees
__ Ankles
__ Feet

**Digestive:**
__ Poor Appetite
__ Belching/Gas
__ Constipation
__ Diarrhoea
__ Nausea
__ Ulcer
__ Vomiting

**Eye, Ear, Nose, Throat:**
__ Allergies
__ Frequent Colds
__ Glasses or Contacts
__ Hearing Aid
__ Hearing Loss
__ Sinus Infection
__ Swollen Glands

**Reproductive:**
__ Pregnant
due date:
__ Painful Menstruation
__ Heavy Flow
__ Irregular Cycle
__ Swollen Breasts
__ Menopausal
__ Pre-menopausal

**Respiratory:**
__ Chronic Cough
__ Bronchitis
__ Asthma
__ Hay Fever
__ Difficulty Breathing
__ Smoking
__ Emphysema
__ Pneumonia

**General Symptoms:**
__ Fainting
__ Dizziness
__ Loss of Sleep
__ Nervousness
__ Fatigue
__ Sudden Weight Loss/Gain
__ Numbness
__ Tingling
__ Paralysis

**Cardiovascular:**
__ High Blood Pressure
__ Low Blood Pressure
__ Coronary Heart Disease
__ Heart Attack
__ Phlebitis
__ Stroke / CVA
__ Pacemaker
__ Heart Murmur
__ Palpitations
__ Varicose Veins
__ Swelling of the Ankles
__ Poor Circulation

__ **Motor Vehicle Accidents?**
Please indicate when, what injuries?

**Previous accidents, injuries, surgeries:**

Please read carefully, and sign.

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I am responsible for notifying my therapist if I am currently experiencing a cold/flu, fever, infection or any contagious disease
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I also understand that I am responsible for any charges incurred in the course of my treatment and that 24 hours notice is required to cancel an appointment, or full charges will apply.
- Payment, in full, will be due at the time of treatment.
- I understand that although massage or other integrative therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
- This is a therapeutic or relaxation massage (or other integrative therapy) and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
- Being that massage (or other integrative therapy) should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature______________________________________ Date__________________

I became aware of *Tree Frog Massage Therapy* through ______________________________________________

I would like to receive occasional information regarding Massage Therapy and wellness Yes No

(Information will also be available on the Tree Frog Massage Therapy Facebook page.)

I would like to receive reminders of upcoming appointments Yes No

You are able to change your e-mail preferences at any time.