Jaime Chandra Kozlowski, RYT, LMBT #7777

Confidential Contact Information, Health History & Informed Consent

Name _____ Date of Birth _____

Address _____ Cell Phone _____

City, State & Zip _____ Alt. Phone _____

Emergency Contact _____ Phone _____

Email Address _____

❑ Check here if you ***do not*** wish to receive infrequent updates, specials and new services that I offer

Have you received professional Massage, Bodywork, or energy work in the past? _____

If yes, what type and what was your experience? _____

_____

What is your primary reason for this visit? _____

_____

What are your long term goals regarding your health? _____

_____

Occupation(s), Daily Activities / Hobbies _____

_____

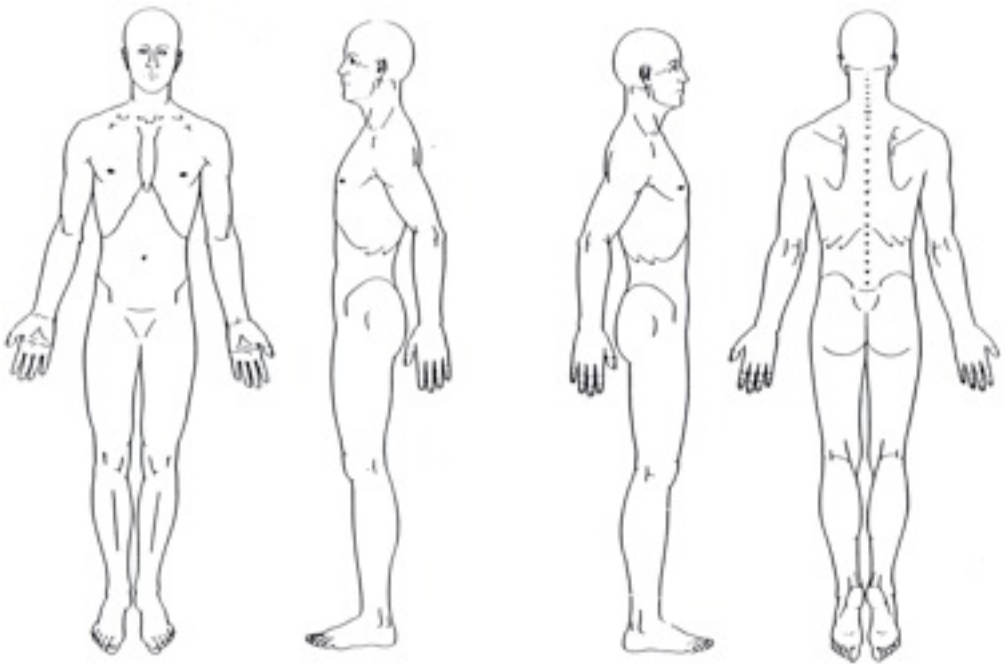
Do you exercise regularly?_____ Describe activities & frequency:_____

_____

Using the provided key, please mark the body chart below.

*Are there any areas that you **would NOT like touched**?* _____ *Please* ✕ *the areas this applies to.*

O Circle areas where you are experiencing **PAIN**
♒ **Squiggly Line** areas of **NUMBNESS** OR **TINGLING**
✳ **Asterisk** areas of **JOINT** & **MUSCLE STIFFNESS**
♓ Mark **SCARS**, **BRUISES**, or **OPEN WOUNDS**



What makes your areas of tension feel better? _____

What makes them feel worse?_____

What causes stress for you?_____

How do you handle stress? _____

_____

How much time per week do you spend taking time to relax and care for yourself? _____

What do you do?_____

Do you have any strong preferences about Aromatherapy? _____

Are you under the care of a: (circle) Medical Doctor - Chiropractor - Naturopath - Homeopath - Therapist

Current Condition(s) Treated _____

Do you wear: (circle) Hard Contact Lenses - Hearing Aid - Dentures - Removable Bridgework - Retainer

Sleeping Patterns: (circle) Restful - Moderate - Oversleep - Disturbed **Average Hours Sleep**: _____

Check condition(s) currently experienced or have experienced in the past.

❑ Severe / Migraine Headaches
❑ TMJ Disorder
❑ Muscle Cramps
❑ Chronic Fatigue
❑ Pins/Wires or Artificial Joints
❑ Tingling, Burning
❑ Loss of Sensation anywhere
❑ Arthritis
❑ Constipation / Diarrhea
❑ Shortness of Breath / Asthma
❑ Sinus Problems
❑ Diabetes
❑ Gout
❑ Epilepsy
❑ Cancer
❑ Psoriasis / Rashes
❑ Hepatitis
❑ HIV / AIDS
❑ Emphysema
❑ High or Low B/P
❑ Varicose Veins
❑ Stroke
❑ Heart Attack, Heart Disorder
❑ Phlebitis/Blood Clots
❑ Pacemaker
❑ Physical/Sexual Abuse
❑ Hearing Problems / Hearing Aid
❑ Food or Nut Allergies - Describe:_____

For Women

❑ PMS / Painful Menstruation
❑ Menopause Complications
❑ Are you Pregnant? How many weeks:_____

If there is anything else you want me to know about you, your health, or your body before working together, please describe: _____

_____

Informed Consent for Massage & Bodywork Session

I understand that the massage/bodywork I receive is provided for the basic purpose of stress reduction, relief of muscular tension/discomfort, improving circulation and enhancing my overall sense of wellness. **If I experience any pain or discomfort during this session I will immediately inform the practitioner so that the heat, pressure or strokes can be adjusted to my level of comfort.** I further understand that massage/bodywork should not be construed as a substitute for medical examinations, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical conditions. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat mental or physical 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 update the practitioner to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

X: _____ **Dated**: _____