Awaken Your Health, LLC

Holistic Bodywork Consultation Form

As a Holistic Health Coach and Bodywork Therapist, I integrate healing therapies, diet and lifestyle support to help the “whole” you to achieve sustainable health and well-being.

Personal Information:

Name: ___________________________ Date: __________________
Address: ______________________________________________________
City: __________________ State: ___________ Zip: ________________
Cell Phone: ___________________ Home Phone: __________________
Email: ________________________ DOB: _________________________
Emergency Contact: ___________________ Phone: __________________
Relationship: ___________________ Occupation: __________________
How did you hear about me? ______________________________________

Massage Information:

Have you had a professional massage before: Yes  No
  If yes, how often do you receive massage therapy? __________________________
What have you enjoyed about your massages in the past? __________________________
What are your goals for your session today? __________________________
Do you have any difficulty lying on your front, back or side? Yes  No
  If yes, please explain: ________________________________________________
Are there any areas you’d like for me to AVOID?
  ___ Feet  ___ Glutes  ___ Pecs  ___ Abdomen  ___ Face  ___ Scalp  Other: __________________________

Current Health:

Please rate you level of energy:  1  2  3  4  5  6  7  8  9  10 (1=little to no energy, 10= high energy)
Do you experience stress in your work, family, or other aspect of your life? Yes  No
  If yes, has it affected your health?
    ___ Muscle Tension  ___ Anxiety  ___ Insomnia  ___ Irritability  ___ Other: __________________________
What areas in your body are you experiencing tension, stiffness, pain or discomfort?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Do you sit for long hours at a computer, work station or driving? Yes  No
  If yes, please describe: ________________________________________________
Do you exercise regularly or actively play in sports? Yes  No
  If yes, please describe: ________________________________________________
Integrative Nutrition:
How many hours of sleep do you get each night? ___ hours
What’s the quality level of your sleep? (Circle) Like a Baby  Restless  Sleep Problems
How many glasses of water do you consume each day? ___ glasses
How much caffeine do you consume each day? ___ cups
How would you rate your diet: 1  2  3  4  5  6  7  8  9  10 (1=needs improvement, 10=Excellent)

Medical History:
Have you had any recent injury or areas of inflammation? Yes  No
If yes, please describe: ________________________________________________________________
Do you have sensitive skin? Yes  No
Do you have any allergies to oils, lotions, essential oils? Yes  No
If yes, please describe: ________________________________________________________________
Do you have any food allergies (exp: nuts, wheat/gluten, eggs, etc.)? Yes  No
If yes, please describe: ________________________________________________________________
Have you been under medical supervision within the last 6 months? Yes  No
If yes, please explain: ________________________________________________________________
Have you had surgery within the past 4 weeks? Yes  No  Please Describe: ___________________
Please list any medications you’re currently taking:
_________________________________________________________________________________
_________________________________________________________________________________

MUSCULOSKELETAL:
__ Bone or joint disease
__ Tendonitis/Bursitis
__ Arthritis/Gout
__ Jaw Pain/TMJ
__ Lupus
__ Spinal Problems
__ Migraines/Headaches
__ Osteoporosis
Please Describe: _____________________________________________________________________

CIRCULATORY:
__ Heart Condition
__ Phlebitis/Varicose Veins
__ Blood Clots
__ High/Low Blood Pressure
__ Lymphedema
__ Lymph Nodes Removed
__ Thrombosis/Embolism
Please Describe: _____________________________________________________________________
RESPIRATORY:
__ Difficulty Breathing/Asthma
__ Emphysema
__ Allergies: Specify: ______________
__ Sinus Problems
Please Describe: ___________________________________________________________

NERVOUS SYSTEM:
__ Shingles
__ Numbness/Tingling
__ Pinched Nerve
__ Chronic Pain
__ Paralysis
__ Multiple Sclerosis
__ Parkinson’s Disease
Please Describe: ___________________________________________________________

REPRODUCTIVE:
__ Pregnant, Stage: ____________
__ Ovarian/Menstrual Problems
__ Prostate
Please Describe: ___________________________________________________________

SKIN:
__ Allergies, Specify: ______________
__ Rashes
__ Athlete’s Foot
__ Herpes/Cold Sores
Please Describe: __________________________________________________________

DIGESTIVE:
__ Irritable Bowel Syndrome
__ Bladder/Kidney Ailment
__ Colitis
__ Crohn’s Disease
__ Ulcer’s
Please Describe: __________________________________________________________

MENTAL/EMOTIONAL:
__ Anxiety/Stress Syndrome
__ Depression
Please Describe: __________________________________________________________
OTHER:
__ Cancer/Tumors
__ Diabetes
__ Contact Lenses
__ Hearing Aids
Please Describe: __________________________________________________________________________

Any other medical condition NOT listed? ______________________________________________________

Is there anything else about your health history that you think would be useful for your massage practitioner to
know to plan a safe and effective massage or reflexology session for you?

__________________________________________________________________________________________

POLICIES:
DRAPIING: You will be securely draped at all times throughout your session. Please undress to your comfort level. Only the
area being worked will be uncovered. Please let me know if you are uncomfortable at any time during your session. ___
(initial)
MINORS: Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 18. ___ (initial)
PAYMENTS: Payments are due in full at the time of your service. You may use cash, check or credit card to make a
payment. If your check has been returned due to insufficient funds, there will be an added $15 processing fee to the
amount due. ___ (initial)
SCHEDULING: It is your responsibility to arrive at or before your scheduled appointment time. Late arrival will result in a
shortened appointment so not to inconvenience other clients. If you are late for your appointment, you will still be charged
the full amount of your session. If you are unable to make your appointment, please give at least 24 hours’ notice of
cancellation to reschedule. A fee of half the service price will be charged if you no-show or cancel without proper notice
and must be paid before your next visit. (initials)
I appreciate your understanding. Please let me know if you have any questions.

CONSENT FOR CARE:
I, ____________________________ (print name) understand that the massage/reflexology I receive is provided for the
basic purpose of relaxation and relief of muscular tension. I further understand that massage/reflexology should not be
considered as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor
or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage
therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental
illness, and that nothing said in the course of the session should be construed as such. Always consult with your
professional healthcare provider before making any changes to your diet, supplements and/or medications.
I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of
appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I
affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the
therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist’s
part should I fail to do so. I will tell my therapist if I am uncomfortable in any way and the therapist, with my help, will
make the appropriate adjustments. I, in signing this consent for Therapy and Waiver of Liability (“Consent”), understand
and agree that this Consent will apply and govern the current and all future therapy sessions performed by Therapist.
Signature of Client: ____________________________ Date: ______________