Confidential Client Medical History & Health Information

Name: _____ Date of Initial Visit _____

Address: _____ Date of Birth _____

_____ Referred By _____

Email _____ Telephone _____ Cell _____

Emergency Contact _____ Telephone _____ Cell _____

Please carefully fill out this medical intake information below. There may be things you do not feel comfortable including until we meet at our first session. I respect the process of disclosing sensitive information. Sharing information about yourself will help me help you. Please check those conditions that have affected your health recently in the past.

- ❑ Arthritis:
  - ❑ Osteoarthritis
  - ❑ Rheumatoid
  - ❑ Psoriatic
- ❑ Osteopenia
- ❑ Diabetes
- ❑ Auto-immune condition*
- ❑ Broken Bones/ Sprains*
- ❑ Cancer *
- ❑ Skin conditions
- ❑ Surgery*
- ❑ Dental Issues*
- ❑ Jaw Pain/TMJ
- ❑ Headaches/ Migraines
- ❑ Heart conditions issues/blood clots
- ❑ High blood pressure
- ❑ Anxiety
- ❑ Depression
- ❑ Seizures or epilepsy
- ❑ Numbness or stabbing pain
- ❑ Drugs*
  - ❑ Prescribed*
  - ❑ Recreational*
  - ❑ Supplement*
- ❑ Sensitive to touch/bruise easily

*Please list specifics. Dates, treatment methods, outcomes, for any items checked above.

_____

Dental History (Surgeries, Orthodontics, TMJ) _____

Falls/Accidents _____

Surgeries (Date/Procedure/Outcome) _____

_____

Drugs(Prescribed/Recreational/Supplements) Reason/dosage _____

_____

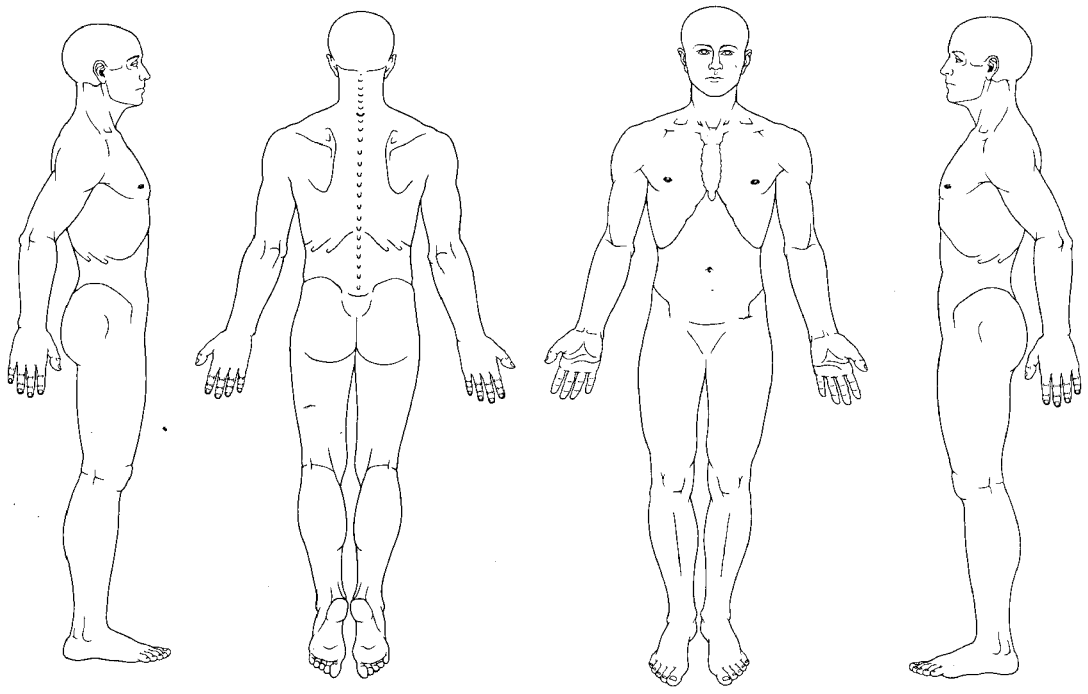
Please list medical providers whose care you are currently under, including all therapeutic modalities i.e. psychotherapy.

_____

Wellness Practices (Exercise/Meditation/Spiritual/Other) _____

_____

Please indicate below areas of discomfort



Informed Consent

I understand the body therapies Liz Hartshorn provides can result in a number of benefits such as relaxation, relief and/or decrease of pain and traumatic stress symptoms, managing acute and chronic conditions. Increased resiliency, and resourcefulness. Like any other treatment, it may also have result in a temporary increase in symptoms. These sessions cannot diagnose illness, disease, or any other physical or mental condition. These sessions are not a substitute for medical treatment and/or diagnosis. I have stated all known medical conditions and will inform my practitioner with updates. I release the therapist from responsibility and liability for any adverse reactions. I reserve the right to tell the therapist when I am uncomfortable with any part of the treatment. I have the right to refuse, stop or terminate treatment at all times, or to refuse techniques, modality or intervention as well as ask any questions. I agree to provide 24-hour cancellation notice. If I fail to do so, I agree to pay the full session fee. I have read the above informed consent, understand, and agree. Please sign below.

Signature _____ Date _____