Confidential Client Medical History & Health Information

Name: _____ Date of Initial Visit _____

Address: _____ Date of Birth _____

_____ Referred By _____

Email _____ Telephone _____ Cell _____

Emergency Contact _____ Telephone _____

What are the main concerns you have for seeking treatment at this time? Please include your symptoms, pain, illness, injuries, functional problems, etc.

_____

_____

What would you like to achieve from therapy (what are your goals)? Include functional goals. _____

_____

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 or in the past.

- ❑ Arthritis:
  - ❑ Osteoarthritis
  - ❑ Rheumatoid
  - ❑ Psoriatic
- ❑ Concussion*
- ❑ 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 these items checked above.
Dental History (Surgeries, Orthodontics, TMJ) _____

_____

Surgeries (Date/Procedure/Outcome) _____

_____

_____

Falls or Motor Vehicle Accidents _____

_____

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

_____

Other life events _____

Wellness Practices (Sleep/Exercise/Meditation/Spiritual/Support Groups/Other)

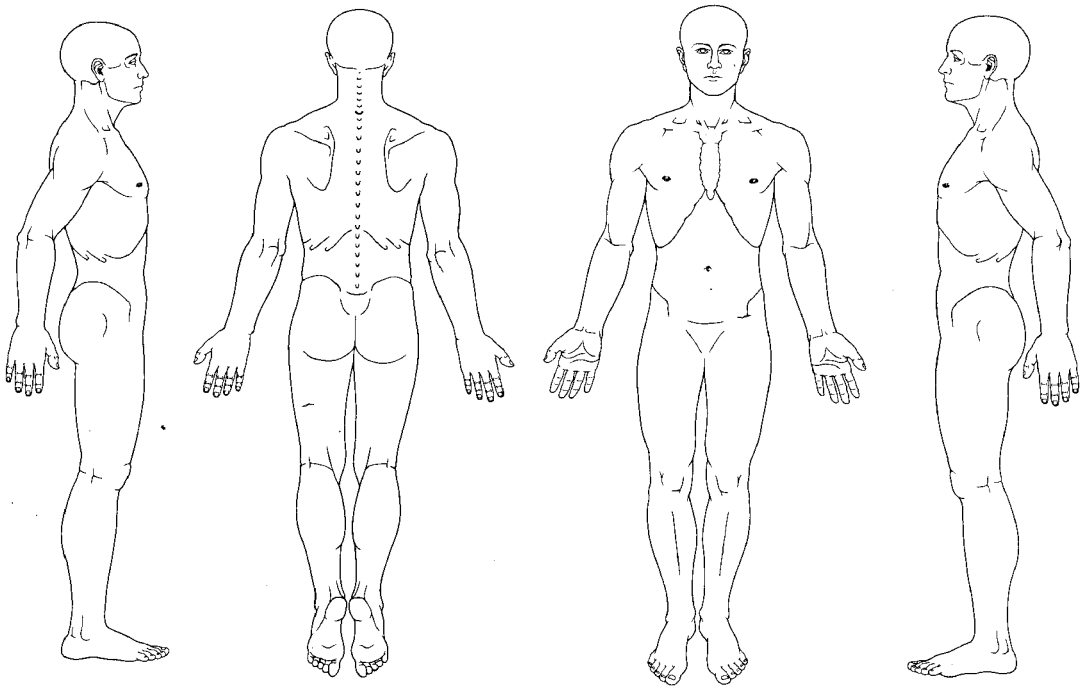
_____

_____

Practitioner Information: There may be times when working collaboratively with your wellness team will be necessary for our sessions together. Please list medical providers whose care you are currently under, including all medical/therapeutic/alternative and psychotherapy modalities. Please initial below to grant me permission to contact your practitioner. You always have the right to revoke this permission at any time.

Practitioner	Modality	Contact Info	Please Initial

Please describe what you feel in your body and mark on the chart where you feel your symptoms.



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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 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 _____