Date: _____

INNER RHYTHMS MANUAL THERAPY

Sandy McClelland, BS, LMT, CNMT
(508) 362-4963

Client Information Form

Name: _____ Telephone # _____

Street: _____ Cell Phone # _____

City: _____ ST. _____ Business # _____

Zip: _____ Occupation: _____

e-mail address: _____ Date of Birth: _____

Have you received Manual Therapy (*CranioSacral , Lymph, Visceral Manipulation*) / Massage? Yes_____ No_____

How did you hear about me? _____

What is the reason for your visit today? _____

_____

Are you under the care physician or other health care practitioner? _____ If yes, for what? _____

_

_____

Are you experiencing pain now? Yes _____ No_____

When did it begin? _____

Check off the sensations: Sharp ____ Dull ____ Tingly _____ Cramping _____ Throbbing _____

Radiating _____ Other: (Describe) _____

List treatments or therapies have you tried? _____

List *all* surgeries you have had: _____

_____

List all medications you are currently taking: _____

_____

Please check off all that apply to you:

- ☐ Aids/HIV
- ☐ Herpes
- ☐ Blood Clot/DVT
- ☐ Cancer or Tumor
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Diabetes
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Epilepsy
- ☐ Seizures

- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Lyme Disease

- ☐ Other: _____

- ☐ Indigestion
- ☐ Diverticulitis
- ☐ Colitis
- ☐ Nervous Stomach
- ☐ Constipation
- ☐ Diarrhea

- ☐ Other: _____

- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Menopause
- ☐ PMS

- ☐ Prostate Problems

- ☐ Adaptive Aids:
- ☐ Pacemaker
- ☐ Stents
- ☐ Plates
- ☐ Screws
- ☐ Rods
- ☐ Other:_____

- ☐ Allergies
- ☐ Headaches
- ☐ Migraines
- ☐ Chronic Pain
- ☐ Neuropathy
- ☐ Arthritis Osteo_____
- ☐ Rheumatoid_____
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Ligament Problems
- ☐ Disc Problems: Where? _____

_____

- ☐ TMJ (Jaw Pain)
- ☐ Knee Replacement
- ☐ Hip Replacement
- ☐ Broken Bones _____
- ☐ Fractured Bones _____
- ☐ Osteoporosis
- ☐ Arthroscopic Surgery

- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Disorders
- ☐ Post-Traumatic Stress Disorder
- ☐ Abuse Issues

- ☐ Hearing Impairment
- ☐ Tinnitus

- ☐ Skin Conditions:
- ☐ Athlete's Foot
- ☐ Ring Worm

- ☐ Pregnant? -------

  How many months_____

- ☐ Contac Lenses

Other congenital or acquired disabilities:

_____

Other infectious diseases: _____

_____

Other comments:_____

_____

Client Confidentiality and Disclosure Agreement

I understand that the treatment here is not a replacement for medical care.

I understand that the therapist/practitioner does not diagnose illness, disease or any other physical or mental conditions.

As such, the therapist/practitioner does not prescribe medical treatment, or pharmaceuticals, nor does she perform any spinal manipulations

I understand that the treatment is not a substitute for medical treatments and or diagnoses and it is recommended that I see a qualified professional for any physical or mental conditions I may have.

I understand that information exchanged during any session is educational in nature and is intended to help you become more familiar and conscious of your own health status and is to be used at your own discretion.

I understand if I am uncomfortable, in any way, with any of the techniques involved in my treatment, I will immediately make my feelings known to the therapist/practitioner.

I also understand that any illicit or sexual suggestions, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled appointment.

CANCELLATION POLICY: *A 24 hour cancellation notice is required. If I do not receive 24 hour notice you will be billed for the missed appointment. Illness and/or emergencies are considered exceptions to the policy.*

Name (signature) _____ Date_____

CONSENT TO TREATMENT OF A MINOR:

By my signature below, I hereby authorize Sandy McClelland to administer Bodywork/Massage techniques to my child or dependant as she deems necessary.
I will be present during each session.

Signature of Parent/Guardian _____ Date: _____