Stefanie Jackson, LMT

Welcome to Point Family Wellness and Chiropractic!

Client General Information

(Please Print in Black or Blue Ink) Today's Date:______/______/______

Name: (First, Last)____________________ Date of Birth:______/______/______

Gender: ☐ Male ☐ Female ☐ Other ☐ Not Specified

Email:____________________ Preferred Phone:____________________ ☐ Cell

Address:____________________ City, State, Zip:____________________

Emergency Contact:____________ Phone:____________ Relationship:____________

Physician Name:____________________ Phone:____________________

Complaint

How did your problem begin:____________________ Date Symptoms Appeared:____________________

Primary Complaint:____

____

Past Treatment:____

____

Existing Conditions - Respiratory

Please indicate if have any of the following conditions:

☐ Asthma ☐ Bronchitis ☐ Chronic cough ☐ Emphysema ☐ Shortness of breath

Existing Conditions - Cardiovascular

Please indicate if you have any of the following conditions:

☐ Blood clots ☐ Cardiovascular accident ☐ Cerebral-vascular accident ☐ Cold feet ☐ Cold hands ☐ Heart disease

☐ High blood pressure ☐ Congestive heart failure ☐ Heart attack ☐ Myocardial infarction ☐ Pacemaker ☐ Phlebitis

☐ Low Blood Pressure ☐ Lymphedema ☐ Stroke ☐ Thrombosis/Embolism ☐ Varicose Veins

Existing Conditions - Skin

Please indicate if you have any of the following conditions:

☐ Bruise easily ☐ Hypersensitive reaction ☐ Melanoma ☐ Skin conditions ☐ Skin irritations

Existing Conditions – Head & Neck

Please indicate if you have any of the following conditions:

☐ Ear problems ☐ Headaches ☐ Hearing loss ☐ Jaw pain (TMJD) ☐ Migraines ☐ Sinus problems

☐ Vision loss ☐ Vision problems

Existing Conditions – Infectious Conditions

Please indicate if you have any of the following conditions:

☐ Athlete's Foot ☐ Hepatitis ☐ Herpes ☐ HIV ☐ Respiratory conditions ☐ Skin conditions

Existing Conditions – Women

Please indicate if you have any of the following conditions:

☐ Gynecological conditions ☐ Pregnancy

Existing Conditions – Soft Tissue/ Joint Dysfunction

Please indicate if you have soft tissue/joint dysfunction in any of the following areas:

☐ Ankle (Left) ☐ Ankle (Right) ☐ Arm (Left) ☐ Arm (Right) ☐ Foot (Left) ☐ Foot (Right) ☐ Hand (Left) ☐ Hand (Right)

☐ Hip (Left) ☐ Hip (Right) ☐ Knee (Left) ☐ Knee (Right) ☐ Leg (Left) ☐ Leg (Right) ☐ Lower Back (Left)

☐ Lower Back (Right) ☐ Mid Back (Left) ☐ Mid Back (Right) ☐ Neck (Left) ☐ Neck (Right) ☐ Shoulders (Left)

☐ Shoulders (Right) ☐ Upper Back (Left) ☐ Upper Back (Right)

Existing Conditons - Family History

Please indicate if you have a family history of following conditions:

☐ Cardiovascular conditions ☐ Respiratory conditions

Existing Conditions – Miscellaneous

Please indicate if you have any of the following conditions:

☐ Allergies ☐ Anaphylaxis ☐ Artificial joints/special equipment ☐ Arthritis ☐ Cancer ☐ Crohn's Disease

☐ Digestive Conditions ☐ Dizziness ☐ Diabetes ☐ Epilepsy ☐ Fibromyalgia ☐ Gout ☐ Hemophilia ☐ Insomnia

☐ Loss of sensation ☐ Lupus ☐ Mental Illness ☐ Osteoarthritis ☐ Osteoporosis ☐ Other diagnosed diseases

☐ Other medical conditions ☐ Rheumatoid Arthritis ☐ Shingles ☐ Stress ☐ Surgical pins or wire

Allergies and other conditions your provider should be aware of:____

Existing Conditions – Neurological

Please indicate if you have a family history of following symptoms or conditions:

☐ Burning ☐ Cerebral Palsy ☐ Herniated disc ☐ Multiple Sclerosis ☐ Numbness ☐ Parkinsons ☐ Stabbing ☐ Tingling

Medications

Please list any medications or drugs you are currently on: *(Please include prescription and over the counter medications)*

Medication	Reason	Medication	Reason

Health Goals

What are your top three health goals:

1.______________________ 2. ______________________ 3.______________________

Do you have any health concerns for other family members today?________________________________

Are you open to other therapies to help improve your care? ☐ Acupuncture ☐ Chiropractic ☐ Nutrition

Client Waiver

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not a qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and nonsexual in nature.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

Signature

I have read the client waiver above and agree to all the policies.

Client Signature:________________________________Date:____________________

Guardian Signature:________________________________Date:____________________

Therapist Signature:________________________________Date:____________________