Serenity Healing Studio Client Questionnaire

BASIC INFORMATION

Name: _____ Date of Birth: _____ Gender: _____

Occupation: _____

How did you hear about us? _____

CONTACT INFORMATION

Email: _____ Phone: _____ mobile ☐

Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____

Phone: _____ Relationship: _____

DOCTOR (OPTIONAL)

Physician Name: _____ Phone: _____

ISSUES TO ADDRESS

Cause of Injury or Concern: _____

_____How Long Since First Noticed: _____

What are your treatment goals? _____

_____

Past Treatment _____

_____

What activities aggravate the symptoms you are experiencing? _____

_____

What have you noticed relieves the symptoms you are experiencing? _____

_____

Has a medical professional advised you against any particular activity? _____

If Yes, what are your restrictions? _____

_____

Additional Concerns or Preferences

Table Heat (Yes or No) _____ Preferred Pressure (light, medium, medium-firm, firm) _____

List any other concerns or preferences here _____

_____

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EXISTING CONDITIONS (please circle all that apply)

RESPIRATORY: Asthma Shortness of Breath Bronchitis Chronic Cough Emphysema

CARDIOVASCULAR: Blood Clots Cold Hands High Blood Pressure Pacemaker Varicose Veins
Cardiovascular Accident Congestive Heart Failure Low Blood Pressure Phlebitis
Cerebral-vascular Accident Heart Attack Lymphedema Stroke Cold Feet Heart Disease
Myocardial Infarction Thrombosis/Embolism

FAMILY HISTORY: Cardiovascular Conditions Respiratory Conditions

SKIN: Bruise Easily Skin Irritations Hypersensitive Reaction Melanoma Skin Conditions

HEAD & NECK: Ear Problems Migraines Headaches Sinus Problems Hearing Loss Vision Loss
Jaw Pain (TMJD) Vision Problems

INFECTIOUS CONDITIONS: Athlete's Foot Respiratory Conditions Hepatitis Herpes HIV Other

WOMEN: Gynecological Conditions Pregnancy

SOFT TISSSUE JOINT DISFUNCTION: Feet Left / Right Ankles Left / Right Legs Left / Right Knees Left / Right
Hips Left / Right Lower Back Left / Right Mid Back Left / Right Upper Back Left / Right
Arms Left / Right Hands Left / Right Shoulders Left / Right Neck Left / Right

NEUROLOGICAL: Burning Numbness Tingling Cerebral Palsy Parkinson's Herniated Disk Stabbing Pain
Multiple Sclerosis

MISCELLANEOUS: Allergies Cancer Dizziness Hemophilia Mental Illness Surgical Pins or Wire Anaphylaxis
Crohn's Disease Epilepsy Insomnia Osteo Arthritis Rheumatoid Arthritis Diabetes Fibromyalgia
Artificial Joints / Special Equipment Loss of Sensation Osteoporosis Shingles Arthritis Gout Lupus
Digestive Conditions Stress Other Diagnosed Diseases or Other Medical Conditions (List Below)

ALLERGIES: _____ _____

OTHER MEDICAL CONDITIONS: _____

MEDICATIONS: _____

SURGERIES: _____

COVID-19: (Have you or anyone in your home experienced the following?)

Fever of 100° F or higher in the last 24 hours Any respiratory / flu symptoms, sore throat, or shortness of breath

Been in contact with anyone who has had symptoms or tested positive for COVID-19 in the last 14 days

Travelled out of the country or visited an area that is considered a "hot spot" for the coronavirus in the last 30 days

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 have also signed the informed consent Client Waiver Form.

Client Signature*_____ Date*_____