postural evolution

1800 30th Street Suite 220
Boulder, CO 80301
(303) 709-7525

Date _____

Client Contact Information

Name:_____ D/O/B: _____

Address:_____

city: _____zip _____

Phone:_____Email: _____

Referred by:_____

Emergency Contact:_____ PH#: _____

Physician/Health Care Provider: _____

Do you have a prescription? ☐ Yes ☐ No

List and date all surgeries and hospitalizations:_____

List all medications:_____

Primary Complaint:_____

Secondary Complaint:_____

Do you have a heart condition? ☐ Yes ☐ No
If yes, please explain: _____

Have you had or currently undergoing treatment for cancer? ☐ Yes ☐ No
If yes, please explain: _____

Do you have any current skin infections or rashes? ☐ Yes ☐ No
If yes, please explain: _____

Check any of the following health conditions that you currently have. If you are unsure, please ask. Please answer honestly, as certain types of manual therapies may or may not be indicated for the conditions listed below.

☐ Blood Clots ☐ Contagious Diseases ☐ Congestive Heart Failure ☐ Infections ☐ Pitted Edema

Please indicate conditions that you have or have had in the past. Please explain in detail including treatments received. Please read through this list and answer all that apply to ensure your therapist affords you the safest treatment modalities to accommodate your specific health history.

Current / Past Joint Pain _____

Current / Past Numbness or Tingling _____

Current / Past Swelling _____

Current / Past Stroke/ Heart Attack _____

Current / Past Varicose Veins _____

Current / Past High/Low Blood Pressure _____

Current / Past C.O.P.D./Emphysema _____

Current / Past Shortness of Breath/ Asthma _____

Current / Past Chronic Pain _____

Current MS/Parkison's _____

Current / Past Epilepsy/Seizures _____

Current / Past Headaches/Migraines _____

Current / Past Dizziness/Ringing in ears _____

Current / Past Digestive conditions (IBS) _____

Current / Past Gas/Bloating/Constipation _____

Current / Past Kidney Disease/infection _____

Current / Past Arthritis (rheumatoid/osteoarthritis) _____

Current / Past Scoliosis _____

Current / Past Lyme Disease _____

Current / Past Broken Bones (list all) _____

Current / Past Allergies _____

Current / Past Hypo/Hyperthyroid _____

Current / Past Depression/ Anxiety _____

Current / Past Concussions _____

Current / Past Motor Vehicle Accidents (list all) _____

Current / Past Traumatic Brain Injuries _____

Current / Past Memory Loss/Confusion/Easily Overwhelmed _____

Additional Comments:_____

Consent for Treatment

Because massage/bodywork/lymphatic therapy should not performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I further understand that massage and bodywork practitioners are not qualified to perform spinal manipulations, diagnose, prescribe, or treat mental illness. I also understand that any illicit or sexually suggestive remarks or advances will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Understanding all of this, I give my consent to receive care.

Client Signature:_____Date:_____

Parent/Guardian Signature: _____ Date: _____

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