

Coreexpressions
Healing for Body, Mind and Spirit
 Tammy Marinaro-Crook RN, BSc BHS

Client Detail Form

Please print ~ Thank you.

Name _____ Phone _____

Address _____ Date of Birth _____

_____ Occupation _____

_____ GP's Name & Phone _____

Email _____

Emergency Contact _____ Phone _____

Before treatment begins it is very important that any recent or chronic medical conditions and any medications you are taking be discussed with the practitioner. A doctor's clearance may be required.

Are you pregnant? Yes No Massage may be contraindicated during the first trimester, therefore treatment is unavailable until after the thirteenth week of pregnancy.

Health and Injury

Accidents w/in last 3 years	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Multiple Sclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Occupational stresses	<input type="checkbox"/> Y <input type="checkbox"/> N
Epilepsy/Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Transmittable diseases	<input type="checkbox"/> Y <input type="checkbox"/> N
Herniated/damaged discs	<input type="checkbox"/> Y <input type="checkbox"/> N		

Please explain anything marked "yes" and detail any other relevant conditions:

Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Earaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Numbness anywhere	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis/Joint Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Eczema	<input type="checkbox"/> Y <input type="checkbox"/> N	Phlebitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Psoriasis	<input type="checkbox"/> Y <input type="checkbox"/> N
Athlete's Foot	<input type="checkbox"/> Y <input type="checkbox"/> N	Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N	Rashes	<input type="checkbox"/> Y <input type="checkbox"/> N
Back Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Grinding of teeth	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus trouble	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding or bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleeping difficulty	<input type="checkbox"/> Y <input type="checkbox"/> N
Carpal Tunnel Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Thoracic Outlet Synd.	<input type="checkbox"/> Y <input type="checkbox"/> N
Clotting disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Muscle Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	TMJ Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N
Cold hands/feet	<input type="checkbox"/> Y <input type="checkbox"/> N	Neck Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Varicose Veins	<input type="checkbox"/> Y <input type="checkbox"/> N

Please explain anything marked "yes" and detail any other relevant conditions:

Please complete overleaf. Thank you.

Coreexpressions
Healing for Body, Mind and Spirit
Tammy Marinaro-Crook RN, BSc BHS

Do you take any medications, vitamins or herbal supplements? Y N

Please list all medications, vitamins and herbal supplements.

Describe your regular exercise and stress management routine:

Please list any injuries you had previously and/or currently have:

Please list any surgeries you had or know you will have:

Please list any prosthetics such as a joint replacement or surgical materials such as staples or pins.

Please list any traumatic or life threatening events that occurred in your life and when they occurred:

What do you hope for and what are your expectations from this treatment today and long-term?

Is there anything else you want to share or want me to know?

Please complete overleaf. Thank you.

I have carefully read all of the above and I have answered all of the questions fully and accurately.

Client Signature _____ Date _____