

# HANDS OF GOLD

~ Extraordinary Therapy ~

## CLIENT INFORMATION FORM

Name \_\_\_\_\_ E-mail address \_\_\_\_\_

Telephone: **Preferred** contact number(s) \_\_\_\_\_ **Home** number (required) \_\_\_\_\_ Fax \_\_\_\_\_

Birth date \_\_\_\_\_ By whom were you referred/**How did you find out about us?** \_\_\_\_\_

Home/Street address (required) \_\_\_\_\_, City \_\_\_\_\_, State \_\_\_\_\_, Zip \_\_\_\_\_

**Mailing address** (if different) \_\_\_\_\_, City \_\_\_\_\_, State \_\_\_\_\_, Zip \_\_\_\_\_

Occupation/Type of work you do \_\_\_\_\_ Employer \_\_\_\_\_

Name, address, & phone number of your physician or primary care provider \_\_\_\_\_

Name, address, & phone number of person to contact in case of emergency \_\_\_\_\_

Spouse or Domestic Partner \_\_\_\_\_

**Primary Reason(s) for seeking our services:** \_\_\_\_\_

Have you recently been involved in a **motor vehicle accident**? If so, please give the date of & some general information about that accident  
\_\_\_\_\_

Have you recently been involved in a **work related accident**? If so, please give details \_\_\_\_\_  
\_\_\_\_\_

Please give us a list of any **past** accidents or injuries you have suffered that may have contributed to the problems you present to us with today. Give the approximate dates & indicate the treatment given at the time, if any \_\_\_\_\_  
\_\_\_\_\_

Names/Types of other providers/practitioners seen for the problem that brings you to our office, approximate dates seen, & results of that care.  
\_\_\_\_\_

Are you currently taking any **medications**? List all medications, the reason for the prescriptions, the name of the prescribing provider, & the approximate date each medication was prescribed.

<u>Name of Medication</u>	<u>Reason for Prescription</u>	<u>Prescribed by</u>	<u>~ Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you presently taking any **supplements**, such as vitamins, minerals, herbs or combinations, or homeopathic remedies? Please list.

<u>Name/Type of Supplement</u>	<u>Reason for Use</u>	<u>Prescribed/Recommended By</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please answer the following questions by marking the appropriate answer. Please use the extra spaces to explain any positive answers.

. *Women only:* Are you currently pregnant? **YES** **NO**  
If so, please state the number of months of gestation & advise us of any pregnancy-related problems you may be experiencing.  
\_\_\_\_\_  
\_\_\_\_\_

. Do you have any known allergies or definite known sensitivities to anything? **YES** **NO**  
List & give type of reaction.

Medications: \_\_\_\_\_  
Inhalants: \_\_\_\_\_  
Plants: \_\_\_\_\_ Animals: \_\_\_\_\_  
Foods: \_\_\_\_\_ Skin sensitivities/allergies: \_\_\_\_\_  
Other/Anything else we should know? \_\_\_\_\_

. Do you now have or have you ever had cancer? **YES** **NO**  
If the answer is yes, please tell us when, the type of cancer, what type of treatment you had, AND give us the name, address, & telephone number of the treating physician(s) \_\_\_\_\_

. Do you have any type of known immune system problems or autoimmune disease? **YES** **NO**

If you are under treatment for this, please give us the name, address, & telephone number of the treating physician(s)

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. Have you ever gone to the Emergency Room for treatment or been hospitalized? Reason: _____	<b>YES</b>	<b>NO</b>
. Have you had any surgeries (please list)?	<b>YES</b>	<b>NO</b>
. Do you have high blood pressure? If you are being treated for high blood pressure, please give us the name, address, & telephone number of the treating physician & be sure to list the medications you are taking above. _____	<b>YES</b>	<b>NO</b>
. Do you have any known heart, cardiovascular or circulatory problems?	<b>YES</b>	<b>NO</b>
. Do you have any problem with blood clot formation, or do you have a known clotting disorder?	<b>YES</b>	<b>NO</b>
. Have you ever suffered a stroke? History: _____	<b>YES</b>	<b>NO</b>
. Have you been diagnosed with any other types of conditions we should be aware of?	<b>YES</b>	<b>NO</b>
. Do you suffer from migraines? . Do you have frequent headaches?	<b>YES</b> <b>YES</b>	<b>NO</b> <b>NO</b>
. Do you ever have episodes of blurred vision or losses of vision?	<b>YES</b>	<b>NO</b>
. Do you suffer from tension or stress related problems? Please explain: _____	<b>YES</b>	<b>NO</b>
. Are you constantly tired?	<b>YES</b>	<b>NO</b>
. Do you suffer from insufficient sleep or have you been diagnosed with a sleep disorder?	<b>YES</b>	<b>NO</b>
. Do you have any known spinal problems? Please give details: _____	<b>YES</b>	<b>NO</b>
. Do you have osteoporosis? . Do you have rheumatic arthritis or osteoarthritis?	<b>YES</b> <b>YES</b>	<b>NO</b> <b>NO</b>
. Do you have chronic or long-term pain in your back or any other area(s)?	<b>YES</b>	<b>NO</b>
. Do you suffer from numbness, tingling, or radiating pain down your arms or legs? Please describe: _____	<b>YES</b>	<b>NO</b>
. Do you find that your everyday functioning is limited in any way by conditions in your body? If yes, please list. _____	<b>YES</b>	<b>NO</b>
. Have you ever had a professional massage of any kind before? . Have you ever had a specifically therapeutic/medical/rehabilitative massage?	<b>YES</b> <b>YES</b>	<b>NO</b> <b>NO</b>

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