KAREN TOWNSEND
holistic transformative bodywork

Holistic Abdominal Relief Therapy

Client Health History

Name_____ Date of First Appointment _____

Address _____

Home phone _____ Cell/work phone _____

Emergency contact _____ phone number _____

Gender Identifying _____ Your age _____

Your Occupation _____

Marital status _____ If not married, do you have a significant other? _____

Children?_____ Ages _____

Date of birth _____ e-mail address _____

What alternative therapies have you experienced?_____

How long ago? _____Frequency? _____

Do you stretch? _____ How often? _____

Do you exercise regularly or participate in sports? _____ What? _____How often? _____

What is your current stress level?

(low) 1 2 3 4 5 (high) _____

Is the stress:

positive | negative | both _____

How many hours do you sleep each night? _____

Do you usually wake feeling:

rested | tired | other _____

Anxiousness:

Often | Sometimes | Seldom _____

Depression:

Often | Sometimes | Seldom _____

_____

_____

_____

What is your major area of pain and/or concern?_____When did you first notice it? _____

What brought it on? _____What activities aggravate it? _____

Is this condition getting worse?_____

Does it interfere with: work | sleep | recreation _____

At or around the time of the onset were there emotional stresses occurring? _____

What do you believe is wrong with you? _____

What have you done to get relief? _____

Have you sought a diagnosis? _____ Diagnosis _____

By whom? _____

Other areas of pain and/or concern _____

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DIGESTION AND DIET

Typical breakfast _____ lunch _____

dinner _____ snacks _____

How many meals per week do you eat fast food, takeout, or dine out? _____

How many **times per week** do you have:

beef ____	chicken ____	fish ____	pork ____
white bread ____	white rice ____	crackers, chips,pretzels ____	cow milk ____
ice cream ____	cheese ____	other dairy ____	desserts ____
canned food ____	soda pop ____		

Do you add salt to your food? _____What would you say is the worst thing you eat? _____

Indicate the following habits with the applicable letter: **H**-heavy | **M**-moderate | **L**-light | **N**-none

Alcohol ____ Coffee ____ Tea ____ Colas ____ Tobacco Marijuana ____ other _____

How much WATER do you drink per day? _____

Are you subject to stress or binge eating? _____ On what foods? _____

What food do you find to be your weakness? _____

Appetite (check one) GOOD ____ FAIR ____ POOR ____

Digestion (check one) GOOD ____ FAIR ____ POOR ____

Do you experience bloating/gas after meals? _____ Do you have sour burps? _____ heartburn? _____

Do you feel SLEEPY after meals? _____ If so, how often? _____

Are you on a restricted diet? _____

Please explain _____

How often do you have a BOWEL movement? _____ Do your stools: ☐ sink ☐ float ☐ both

Have you ever had: hard stools? ____ how often? ____ loose stools? ____how often? ____

URINATION (check all that apply)

____ Normal ____ Scanty ____ More Than 5xs Daily ____ Burning ____ Strong Odor ____ Dark Color

Typical COLOR _____

Is there any history of bladder or kidney infections? _____ If so, at what age? _____

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FAMILY HISTORY

Is family history known? _____

Please list: *1. Alive? 2. Age/Cause of Death 3. Major ailments while alive*

MOTHER 1. _____ 2. _____ 3. _____

Maternal Grandmother 1. _____ 2. _____ 3. _____

Maternal Grandfather 1. _____ 2. _____ 3. _____

FATHER 1. _____ 2. _____ 3. _____

Paternal Grandmother 1. _____ 2. _____ 3. _____

Paternal Grandfather 1. _____ 2. _____ 3. _____

(OPTIONAL) Is there a history of abuse in your family? _____ (circle one) emotional | physical | sexual | spiritual

EMOTIONAL AND SPIRITUAL

If romantically involved, how is your relationship? _____ Is your love life satisfying? _____

Were/are there any emotional traumas in your early or present life? (i.e. rape, great loss, suicide, death of a loved one, etc.)

_____

_____

If possible, please explain the negative emotion you experience most _____

When do you most often feel this emotion? _____

What is your opinion of yourself? _____

Have you ever been to counseling? _____ If so, what was the outcome? _____

Do you pray? _____ If so, how often? _____

Do you meditate? _____ If so, how often? _____

Rate yourself: **N** - none | **S** - some | **L** - lots

Faith _____ Hope _____ Charity _____ Generosity _____ Sense of humor _____ Sense of fun _____

Is there an unrealized longing in your life? _____ If so, what is it? _____

Are you involved in activities outside of work? _____ If so, what type? _____

Hobbies and/or interests _____

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BIRTH AND EARLY CHILDHOOD

My birth was: (check one) ____Normal ____Difficult ____Unknown

Please explain _____

_____

Briefly explain your early relationship with each of your parents _____

_____

Briefly explain your present relationship with each of your parents _____

_____

MEDICAL HISTORY

What is your blood type? (A, AB, B, 0) _____

Are you currently under the care of a doctor, chiropractor or other health care practitioner? _____

If so, for what condition? _____

Name of practitioner/clinic_____

City _____ State _____Phone _____

List any medications you are taking_____

For how long? _____ Do you have allergies? _____

Previous **broken bones** including year _____

Previous **accidents** including year_____

Previous **surgeries** including year_____

Other **hospitalizations** including year _____

Childhood accidents or physical traumas _____

List any medications you took as a child and how long taken _____

_____

Have you ever hit or fallen on your head or tailbone? _____ Did you suffer trauma at birth? _____

Did you or have you ever had an inguinal hernia or surgery for an inguinal hernia?_____

Please explain_____

_____

Did you or have you ever had a hiatal hernia? _____

Please explain_____

_____

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Mark ***current*** problems with a "**C**" mark ***past*** problems with a "**P**"

C	P		C	P		C	P	
☐	☐	headaches	☐	☐	asthma	☐	☐	contact lenses or dentures
☐	☐	constipation	☐	☐	allergies	☐	☐	fatigue
☐	☐	arthritis, osteoporosis, brittle bones	☐	☐	pregnancy	☐	☐	diabetes
☐	☐	hepatitis	☐	☐	varicose veins/circulatory problems	☐	☐	cold hands
☐	☐	swollen ankles	☐	☐	sinus trouble	☐	☐	heart pain
☐	☐	cold feet	☐	☐	painful joints	☐	☐	swollen joints
☐	☐	face flushed	☐	☐	tightness in shoulder blades	☐	☐	fainting spells
☐	☐	emotional problems	☐	☐	anorexia/bulimia	☐	☐	heart problems
☐	☐	kidney problems	☐	☐	bad breath	☐	☐	ringing in ears
☐	☐	tightness in throat	☐	☐	loss of smell	☐	☐	loss of taste
☐	☐	muscle spasms in neck	☐	☐	grating in neck	☐	☐	blood clots/phlebitis
☐	☐	loss of memory	☐	☐	frequent cold or flu	☐	☐	numb hands or feet
☐	☐	head feels too heavy	☐	☐	pinched nerve in back	☐	☐	herniated or bulging disc
☐	☐	epilepsy or other seizures	☐	☐	pains in legs and feet	☐	☐	shooting pain in head
☐	☐	high or low blood pressure	☐	☐	spinal problems	☐	☐	pins & needles in legs
☐	☐	pins & needles in back	☐	☐	pins & needles in arms and hands	☐	☐	sciatica
☐	☐	painful menstruation/cramps	☐	☐	lung or breathing problems	☐	☐	cancer
☐	☐	skin disorders, acne, fungus, rash	☐	☐	sensitivity to oils and lotions	☐	☐	depression

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Please read and sign.

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I agree to give at least 24-hours notice of cancellation of an appointment. cases of extreme emergency are considered exceptions to this cancellation policy.

I understand the treatment here is not a replacement for medical care. I understand the therapist does not diagnose medical illness, disease, or any other physical or mental condition. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. I understand that the treatment is not a substitute for medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my health.

Client signature _____ Date _____

Certified H.A.R.T. Method Practitioner
Therapeutic Massage
Shiatsu
Thai Massage

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