



Health History & Client Information

***All information collected is confidential ***

Name _____ DOB _____

Spouse/Partner _____ DOB _____

Children with DOB _____

Occupation _____

Address _____

Phone-Home _____ Phone-Cell _____ Phone-Work _____

Email _____

Emergency Contact Name & Number _____

How did you hear about us? _____

I am interested in the following Hopewell Center Services (circle all that apply):

Labor Doula

Postpartum Doula

Sibling Doula

Massage Therapy

Belly Casting

Henna Body Art

Childbirth Education

Parenting Education

Special Topic Workshop/Seminars

Dietitian Consultation

I would like a referral for the following product(s) or service(s): _____

Name and location of Family Care Physician and Prenatal Care Provider (if applicable)

Are you currently taking any medications? Please include Prescription, Herbal, and Over the Counter medications and the reason for taking them:

Allergies (incl. allergies to medications, environmental allergies, and food allergies) _____

Surgeries/Accidents, including year _____

******IMPORTANT******Please indicate if any of the following conditions apply to you because standard massage therapy techniques may not be appropriate.

- | | | |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Recent Injury |
| <input type="checkbox"/> HIV/Hepatitis/Infectious Disease | <input type="checkbox"/> Swelling/Edema | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Open Cuts/Sores | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Chronic Pain Treatment | <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Neuropathy/Numbness | <input type="checkbox"/> Fibromyalgia/Lupus | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Fever/Acute Infection | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Varicose Vein |
| <input type="checkbox"/> Disease of Heart/Blood Vessels | <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Pre-term Labor |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> 'Morning' Sickness | <input type="checkbox"/> Pre-Eclampsia |

***By signing and dating this form, you acknowledging that...

- ...the information you have provided is complete and correct. You also agree to inform your Massage Therapist of any changes pertaining to this information.
- ... you have read the Hopewell Center for Perinatal Services Client Policies and agree to abide by them.
- ... you have read and understand your Client Bill of Rights.

Your personal information is protected by the HIPAA law and this office will abide by the law.***

Sign_____

Date_____

Witnessed By _____

Date_____

Updated 8.19.2008