CONFIDENTIAL

Client Information
Please Print Clearly

GENERAL INFORMATION Today's Date ________________

Last Name ____________________________ First Name ________________________ MI ______

Would you prefer to be called by another name? ____

If under the age of 18, name of Parent/Guardian ____

❐ Male ❐ Female Date of Birth ____________________________

Street Address ____

City ______________________________________ State ________ Zip ______________________

Cell Phone __________________________ Home Phone ______________________________

Work Phone _________________________ Occupation ______________________________

E-mail Address: ____

❐ I prefer to receive appointment confirmations via email.

❐ I prefer to receive appointment confirmations via text message. Cell phone carrier ________________

❐ I prefer to receive appointment confirmations via both email & text message.

Emergency Contact ____ Relationship ________________

Emergency Contact Phone ______________________________________ ❐ Cell ❐ Home ❐ Work

How did you hear about Women 2 Women Restorative Therapy? Check all that apply.

- ❐ Referring Health Practitioner (Name: ____)
- ❐ Client or W2W Staff (Name: ____)
- ❐ Event (Which Event? ____)
- ❐ Newspaper/Magazine Ad (Which Ad? ____)
- ❐ Internet (Referring website or Search engine? ____________________________________)
- ❐ Other ____

24 Hour Cancelation Policy

We look forward to serving you and all our clients. Please be advised that last minute cancellations and "no shows" prohibit other clients from utilizing our services.

I understand that in the event that I do not give 24 hours notice of cancellation, except in the case of emergencies, I will assume responsibility for payment of the full fee. Medical emergencies, death in the family, and incapacitating illness constitute legitimate waivers of the cancellation fee, that is, it you will not be charged in these cases. Likewise, when Women 2 Women Restorative Therapy personnel cancel appointments with less than 24 hours notice, except in the case of emergencies, your next session will be at no charge.

Situations such as traffic delays, business emergencies, car trouble, lack of childcare, incorrect entry of appointment date or time into your electronic devices, do not constitute cause for waiving the cancellation charge. However, in any event, we will make every effort to fill your appointment. If we do fill the appointment you will not be charged a cancellation fee.

Similarly, being late for a session compromises the level of service rendered by creating sessions that cannot be properly completed, along with added stress.

I understand that when I am late for a session, I will receive whatever time is remaining if a partial session is possible. If Women 2 Women Restorative Therapy personnel are late, we will do our best to provide for a full treatment at your scheduled time. In the event that a full treatment is not possible, compensation will be provided.

____
Print Name

____
Signature

_______/_______/_________
Date

Your Understanding is Greatly Appreciated!

CURRENT CONDITIONS

List **primary** areas of discomfort or pain that prompted you to seek therapeutic body work now. ________

____

____

Describe the onset of the discomfort or pain. ____

____

What is the frequency? ❑ Constant ❑ Off/On ❑ Cyclic ❑ Infrequent

Is it ❑ Getting Better? ❑ Getting Worse? ❑ Staying the same?

Is there anything that you do that *creates* or *increases* the pain? ❑ Yes ❑ No Please explain.

____

Is there anything that you do that *decreases* the pain? ❑ Yes ❑ No Please explain.

____

At what time is the pain the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ During sleep ❑ At Rest ❑ With Activity

Have you received treatment before for this specific problem? ❑ Yes ❑ No

If yes, what/when? ____

Was the treatment effective? ❑ Yes ❑ No Please explain.______________________________

____

List **additional** areas of discomfort or pain. ____

____

____

Describe the onset of the discomfort or pain. ____

____

What is the frequency? ❑ Constant ❑ Off/On ❑ Cyclic ❑ Infrequent

Is it ❑ Getting Better? ❑ Getting Worse? ❑ Staying the same?

Is there anything that you do that *creates* or *increases* the pain? ❑ Yes ❑ No Please explain.

____

Is there anything that you do that *decreases* the pain? ❑ Yes ❑ No Please explain.

____

At what time is the pain the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ During sleep ❑ At Rest ❑ With Activity

Have you received treatment before for this specific problem? ❑ Yes ❑ No

If yes, what/when? ____

Was the treatment effective? ❑ Yes ❑ No Please explain.______________________________

____

HEALTH INFORMATION

Occupation ____

Work-related activities ____

____

Do you spend more than 60 minutes/day driving? ❑ Yes ❑ No

List any stress reduction and exercise activities. (Include frequency.) ________________________

____

____

What hobbies do you enjoy? (Include frequency of participation.) __________________________

____

____

Explain any of the following. Include year and treatment received.

Surgeries: ____

____

____

Injuries/Accidents (Recreational, Auto, Work-related, Falls, etc.): ________________________

____

____

____

Major illnesses and hospitalizations: ____

____

____

Please list any activity you used to be able to do, but now are unable to do. ___________________

____

In what position do you most often fall asleep? ❑ Back ❑ Left Side ❑ Right Side ❑ Stomach

In what position do you most often wake up? ❑ Back ❑ Left Side ❑ Right Side ❑ Stomach

Do you consistently receive at least 5 hours of uninterrupted sleep? ❑ Yes ❑ No

If “no,” what interrupts your sleep? ____

GENERAL HEALTH HISTORY

Are you currently under the care of a Health Care Practitioner? ❑ Yes ❑ No

If yes, please give name(s) and location(s). ____

____

____

List all current medications (including regular use of over-the-counter meds). Use back if necessary.

Medication	For treatment of	Amount	Effectiveness

List current vitamin, mineral, or herbal supplements, homeopathic preparations, or essential oils.

____

____

____

List known allergies: ____

Please indicate anything else about yourself that you suspect may be contributing to your condition. _____

____

____

In the space below, please list and date chronologically any life changes in occupation, relationships, residence, physical or mental health in the past 10 years (e.g. moves, change in financial status, marriage, divorce, family additions, death of family member/close friend, time caretaking, illness diagnosis, etc.). Use the back of the page if more room is required.

Please mark any of the following that you **now have** or **have had in the past**.
Circle applicable condition where two are listed on the same line, or **circle right or left** when applicable.

Musculoskeletal

Past Now

Head

- ❑ ❑ Temples
- ❑ ❑ Forehead
- ❑ ❑ Top of head
- ❑ ❑ In the eyes
- ❑ ❑ Entire head
- ❑ ❑ Base of skull
- ❑ ❑ TMJ
- ❑ ❑ Dizziness / Spacey
- ❑ ❑ Fainting / Light headedness
- ❑ ❑ Pain in ears
- ❑ ❑ Ringing in ears
- ❑ ❑ Pain in teeth

Neck

- ❑ ❑ Throat pain
- ❑ ❑ Neck stiffness
- ❑ ❑ Pain at neck-shoulder junction (R-L)
- ❑ ❑ Pain with side-to-side head movement
- ❑ ❑ Neck feels out of place
- ❑ ❑ Muscle spasm in neck
- ❑ ❑ Grinding/grating sound w/ neck movement
- ❑ ❑ Diagnosed arthritic neck
- ❑ ❑ Diagnosed disc herniation (Level ______)
- ❑ ❑ Diagnosed bone spurs

Shoulders

- ❑ ❑ Pain – Front (R-L)
- ❑ ❑ Pain – Back (R-L)
- ❑ ❑ Pain – Side (R-L)
- ❑ ❑ Pain - Deep in shoulder joint (R-L)
- ❑ ❑ Diagnosed bursitis
- ❑ ❑ Diagnosed arthritis
- Can't raise arm (R-L)
  - ❑ ❑ Above shoulder level
  - ❑ ❑ Overhead

Back

- ❑ ❑ Pain between the shoulder blades
- ❑ ❑ Pain across midback
- ❑ ❑ Pain with breathing
- ❑ ❑ Pain across low back
- ❑ ❑ Pain up and down back
- ❑ ❑ Diagnosed pinch nerve in low back
- ❑ ❑ Diagnosed arthritis
- ❑ ❑ Diagnosed disc herniation (Level ______)
- ❑ ❑ Pain in the sacram / coccyx

Past Now

Hips

- ❑ ❑ Pain in buttocks
- ❑ ❑ Pain while standing
- ❑ ❑ Pain while sitting
- ❑ ❑ Pain on side of hip (R-L)
- ❑ ❑ Pain deep in hip joint (R-L)
- ❑ ❑ Pain on sit bones
- ❑ ❑ Diagnosed bursitis
- ❑ ❑ Diagnosed arthritis

Arms

- ❑ ❑ Pain in upper arm (R-L)
- ❑ ❑ Pain in forearm (R-L)
- ❑ ❑ Pain in wrist (R-L)
- ❑ ❑ Pain in fingers (which?)
- ❑ ❑ Sensation of pins & needles in fingers
- ❑ ❑ Fingers go to sleep
- ❑ ❑ Hands cold
- ❑ ❑ Swollen joints in fingers
- ❑ ❑ Sore joints in fingers
- ❑ ❑ Diagnosed arthritis
- ❑ ❑ Loss of grip strength

Legs & Feet

- ❑ ❑ Pain down both legs
- ❑ ❑ Pain down one leg (R-L)
- ❑ ❑ Leg cramps
- ❑ ❑ Pins & needles in legs (R-L)
- ❑ ❑ Numbness in leg (R-L)
- ❑ ❑ Numbness in feet (R-L)
- ❑ ❑ Numbness in toes
- ❑ ❑ Feel cold
- ❑ ❑ Cramps in feet (R-L)
- ❑ ❑ Swollen ankles (R-L)
- ❑ ❑ Swollen feet (R-L)
- ❑ ❑ Pain in foot (R-L)
- ❑ ❑ Pain in knee (R-L)
- ❑ ❑ Diagnosed arthritis

Other

- ❑ ❑ Bone / joint disease
- ❑ ❑ Tendonitis / bursitis
- ❑ ❑ Sprains / strains
- ❑ ❑ Osteoporosis
- ❑ ❑ Other________________

Past Now

Skin

- ❑ ❑ Rashes
- ❑ ❑ Athletes Foot
- ❑ ❑ Herpes / Cold sores
- ❑ ❑ Other _____________

Nervous System

- ❑ ❑ Shingles
- ❑ ❑ Trigeminal neuralgia
- ❑ ❑ Bells Palsy
- ❑ ❑ Multiple Sclerosis
- ❑ ❑ Neuropathy
- ❑ ❑ Other _____________

Digestive

- ❑ ❑ Constipation / Diarrhea
- ❑ ❑ Gas / Bloating
- ❑ ❑ Indigestion / Heart burn
- ❑ ❑ Diverticulitis
- ❑ ❑ Irritable Bowel Syndrome
- ❑ ❑ Crohns
- ❑ ❑ Ulcers
- ❑ ❑ Other_____________

Respiratory

- ❑ ❑ Breathing difficulties / Asthma
- ❑ ❑ Emphysema
- ❑ ❑ Allergies
- ❑ ❑ Sinus Problems
- ❑ ❑ Snoring
- ❑ ❑ Sleep Apnea
- ❑ ❑ Other______________

Circulatory

- ❑ ❑ Heart Condition
- ❑ ❑ Phlebitis / Varicose veins
- ❑ ❑ Blood Clot(s)
- ❑ ❑ High / Low Blood Pressure
- ❑ ❑ Lymphodema
- ❑ ❑ Thrombosis / Embolism
- ❑ ❑ Other_____________

Past Now

Urinary / Elimination

- ❑ ❑ Urinary Urgency / Frequency
- ❑ ❑ Leaking of Urine
- ❑ ❑ Fecal incontinence
- ❑ ❑ Other _____________

Reproductive

- ❑ ❑ Pregnant: Stage______
- ❑ ❑ Miscarriage
- ❑ ❑ PMS
- ❑ ❑ Ovarian / Menstrual challenges
- ❑ ❑ Pain on intercourse
- ❑ ❑ Prostate challenges
- ❑ ❑ Other______________

Other

- ❑ ❑ Cancer / Tumor
- ❑ ❑ Kidney / Bladder ailment
- ❑ ❑ Diabetes: Type 1 / Type 2
- ❑ ❑ Anemia
- ❑ ❑ Migraines / Headaches
- ❑ ❑ Chronic Fatigue / Fibromyalgia
- ❑ ❑ Lupus
- ❑ ❑ Chronic Pain
- ❑ ❑ Anxiety / Stress
- ❑ ❑ Depression
- ❑ ❑ Alcoholism
- ❑ ❑ HIV / AIDS
- ❑ ❑ Stroke

Other unlisted conditions

- ❑ ❑ _________________________
- ❑ ❑ _________________________

Below is a list of common daily activities.

- "# min." = The activity begins okay, but becomes uncomfortable or painful. Write the length of time you are able to perform the task before it is uncomfortable.
- "D" = You are able to perform the task but with difficulty.
- "X" You are unable to perform the task.

standing	______	kneeling	_____	grocery shopping	____
sitting	______	bending to wash face or brush teeth	_____	carrying groceries	____
walking	______	picking up something off the floor	_____	picking up small objects	____
walking up stairs	______	lifting a child	_____	grasping / holding objects	____
walking down stairs	______	getting something above your head	_____	opening jars	____
sleeping	______	washing your hair	_____	typing on computer keyboard	____
lying on your back	______	shaving	_____	getting in/out of car	____
lying on your side	______	stepping into/out of tub	_____	driving	____
getting in/out of bed	______	putting on a shirt or jacket	_____	checking your blind spot	____
getting up from a chair	______	laundry	_____	reading	____
chewing	______	cooking	_____	gardening	____
swallowing	______	making the bed	_____	exercising	____
yawning	______	vacuuming / sweeping	_____	other ___________________	____

Using an "X," make a mark on the line for the following:

What is your **functional ability** on a

good day ____

0% 100%

bad day ____

0% 100%

What is the **pain intensity** on a

good day ____

no pain worst imaginable

bad day ____

no pain worst imaginable

Write your goals for treatment. ____

____

____

____

____

Informed Consent for
Women 2 Women Restorative Therapy Sessions

(Please read before signing!)

I understand that the services I receive from Women 2 Women Restorative Therapy (W2WRT) are for the relief of physical pain, utilizing gentle hands-on techniques directly on skin. While I expect benefits from the treatment, I understand and accept that such benefits and desired outcomes cannot be guaranteed. I understand that my own motivation and regular attendance and participation at scheduled sessions and self-treatment will produce the optimal possible benefit from therapy. I understand that occasionally, referrals are made to other health professionals if deemed appropriate. Additionally, I understand that I am free to discontinue treatment at any time.

I understand that W2WRT sessions do not constitute medical care and that if I have health concerns it is my responsibility to seek professional medical advice. Practitioners of W2WRT are not qualified to diagnose disease or illness, and nothing said during the course of the session should be construed as such. I agree to inform the W2WRT practitioners of any known medical conditions or changes in my health so that practitioners can perform the safest treatment possible.

I understand the practitioner is not providing emergency services and if I have an emergency I should call 911 and/or immediately go to the nearest hospital emergency room.

I understand the relationship between the practitioner and client is a professional one. Requests for friendship between practitioners and clients are not considered beneficial. For the safety and best treatment outcomes for the client, practitioners at W2WRT will not establish friendships with clients. This precaution is for the benefit of the client and ensures that the practitioner maintains the ability to remain in a professional role for the client. Additionally, it is understood that any sexually suggestive remarks or advances made will result in the immediate termination of the session and termination of the professional relationship.

I understand that my participation in W2WRT sessions will remain confidential. Voice mailboxes are confidential. The nature of email is such that if I wish to communicate confidentially, I will not use email but rather use voicemail. If I do choose to communicate via email, I understand and accept that confidentiality cannot be guaranteed by the practitioners. In addition, if I happen to see W2WRT practitioners in public, I understand that the practitioner will not approach me and will only speak with me if I initiate the conversation.

While the work is gentle and will never cause injury, I understand that if at any time I am uncomfortable with or have concerns about the treatment that I am receiving, I will immediately inform the practitioner and treatment will be modified or halted.

I have had the opportunity to discuss all the aspects of Women 2 Women Restorative Therapy sessions fully, have had my questions answered, and understand the treatment planned. I am not aware of any reason why I should not proceed with Women 2 Women Restorative Therapy sessions, and I agree to participate fully and voluntarily.

Client's Printed Name: ____

Client's Signature: ____ Date: ____________________