NATURAL HOPE CENTER
310 W. Wyomissing Blvd
West Lawn, PA 19609

Confidential Client Information & Health History

Name_____ Birthdate_____Age: _____
Address_____
City_____ State_____Zip _____
Phone/Cell:_____Male _____Female _____
Status: Minor_____Single_____Married_____Divorced_____Separated_____Widowed_____
Occupation_____Email_____
Emergency Contact_____ Phone_____
How did you hear about us?_____
Reason for visit?_____
_____
What previous efforts (if any) have you taken to resolve your problem?_____
_____
_____
Are you currently under a doctor/physician or counselor/psychologist care for the related problem? If yes, please explain_____
_____
_____
_____

Medical History
Name of Family Doctor_____ Phone_____
Address_____

Please list all medications you are currently taking (including vitamins, herbs & supplements)_____
_____
_____
_____

I wear Contact Lenses/Glasses_____ Dentures_____HearingAid_____Pacemaker_____

Please describe any surgeries, hospitalizations, accidents or injuries you have had in the past_____
_____
_____
_____
_____
_____
Do you have any chronic or on going pain you deal with on a regular basis? Explain_____
_____
Is there any activity that makes the pain worse?_____
_____

PLEASE COMPLETE OTHER SIDE

Rate your level of stress on a scale of 1 (lowest) to 10 (highest)_____
What causes most of your stress?_____
_____

Please check all current and previous conditions

Current	Past		Current	Past	
_____	_____	Anxiety/Depression	_____	_____	Chronic Pain
_____	_____	Headaches/migraines	_____	_____	Colitis
_____	_____	Skin condition	_____	_____	Ulcers
_____	_____	Allergies (foods)	_____	_____	Diabetes
_____	_____	Allergies (scents/environment)	_____	_____	Heart Disease
_____	_____	Arthritis	_____	_____	Stroke
_____	_____	Asthma	_____	_____	Blood Clots
_____	_____	Fibromyalgia	_____	_____	High blood pressure
_____	_____	Osteoporosis	_____	_____	Low blood pressure
_____	_____	Spinal/disc problems	_____	_____	HIV/AIDS
_____	_____	Neck/shoulder pain	_____	_____	Epilepsy/seizures
_____	_____	Low back/Hip pain	_____	_____	Cancer
_____	_____	TMJ	_____	_____	Pregnancy
_____	_____	Sciatica			When?_____
_____	_____	Numbness/Tingling	_____	_____	Other illnesses

Please explain:_____
_____
_____

Are you pregnant? Yes_____ No_____
Do you drink alcohol? NO_____ Yes _____How often _____
Do you smoke tobacco? Yes_____ No _____
Do you use any illegal drugs? Yes_____ No _____

I, the undersigned, understand all questions and verify that all information is complete and accurate to the best of my knowledge. I also understand that the methods used or products suggested for my wellness program are **NOT a substitute for medical treatment**. I am also aware that Karen O'Connor ND, MS, LMT is a licensed massage therapist and a natural health consultant and is not a physician, nor does she prescribe medication, or claim to cure or diagnose disease. I also understand that massage therapy is a health aid and does not take the place of a physicians' care. Any information exchanged during a massage session is confidential and is only used to provide the best massage care. I agree to pay for services rendered me, the above mentioned client as the charge is incurred. I understand that full payment of services rendered is due at the end of each session. I also understand that Karen O'Connor ND, MS, LMT reserves the right to refuse service to anyone, this includes, but not limited to, anyone who requests services that are outside her scope of practice.

Client's Signature_____ Date_____