

*Valeo Health & Wellness Center
Michelle McKusick, LMT Practitioner*

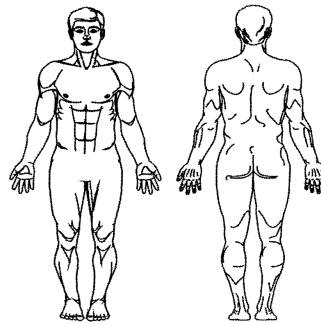
<input type="checkbox"/> CC	<input type="checkbox"/> Thank You Note
<input type="checkbox"/> Eclipse	

Name		Birthdate		Age	Date		
<i>Address</i>		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>Email / Newsletter</i>		
Phone H()		W()	C()	Height	Weight		
Cell Phone Carrier					Gender		
Contact Preference <input type="checkbox"/> Phone (H) <input type="checkbox"/> Phone (W) <input type="checkbox"/> Phone (C) <input type="checkbox"/> Email <input type="checkbox"/> Text							
Employers Name and Address			Occupation				
Emergency Contact Information							
Name		Relationship to Patient		Phone ()			
Please tell us who referred you to our office?				<input type="checkbox"/> Single		<input type="checkbox"/> Married	
				<input type="checkbox"/> Divorced		<input type="checkbox"/> Widowed	
Additional Information							
Language:		Ethnicity:		Race:			
English _____		Hispanic or Latino _____		White _____		Hispanic or Latino _____	
Spanish _____		Not Hispanic or Latino _____		Asian _____		Black or African American _____	
Other _____		Decline to Answer _____		Other _____		Decline to Answer _____	
<p>Goals For My Care: People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction may be. Your practitioner will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes.</p> <p><input type="checkbox"/> Relief Care – Symptomatic relief of pain or discomfort</p> <p><input type="checkbox"/> Corrective Care – Correcting and relieving the cause of the problem as well as the symptoms</p> <p><input type="checkbox"/> Comprehensive Care – Address the entire system and bring whatever is malfunctioning in the body to the highest state of health possible</p>							
Medical Conditions or diagnosis that should be considered prior to therapy:							
Physical Limitations or concerns that should be considered prior to therapy:							
Do you have any other health concerns?							
Would you be interested in an examination by one of our qualified doctors? <input type="checkbox"/> Yes <input type="checkbox"/> No							

List all past accidents (auto or work), injuries, surgeries, X-rays, trauma, or emotional procedures		
Type	Date	Doctor / Hospitalization / X-Rays

Please note body area on the diagram by marking sore area with an X

Body Area	Mild	Severe
Neck	_____	_____
Upper back	_____	_____
Lower back	_____	_____
Abdomen	_____	_____
Chest	_____	_____
Upper arms	_____	_____
Lower arms	_____	_____
Upper legs	_____	_____
Lower legs	_____	_____



Please mark with an "X" any disorder that you have experienced in the last 5 years

CARDIOVASCULAR	NERVOUS SYSTEM	SKELETAL/JOINTS	MUSCULAR SYSTEM
Heart disease (any type)	Chronic pain / Sciatica	Osteoporosis	Muscular tension
Blood Pressure Disorders	Shingles / herpes	Arthritis (any type)	Spasms, cramps
Blood vessel disorders	Spinal cord injuries	Sprains / strains	Fibromyalgia
Bleeding disorders or blood clots	Numbness / tingling	Tendonitis / Bursitis	Jaw pain / TMJ

Details _____

- Are you allergic or sensitive to any oils or fragrance? No Yes to what _____
- Do you take any prescribed medication? No Yes for what _____
- Have you had any surgery in the last year? No Yes for what _____
- Are you pregnant? No Yes due when _____
- Do you exercise regularly? No Yes what activities _____

Authorization of Care:
<p><i>I understand that the therapist is not a doctor; they will not diagnose or prescribe. I understand that applied kinesiology testing and consulting are not designed for, nor are they being used as a means of any diagnosis, treating of a disease or pathology. All test results will be used as indicators of possible stress patterns and areas where the body may be out of balance. These are tools being used in accordance with their design to recognize imbalances in the body's energetic, muscle and cellular systems and then to indicate a solution to clear imbalances through various bodywork and/or nutritional supplements and/or remedies. Even though there will be references to body tissues, organs, or organ systems during the course of our sessions, these references in no way represent diagnoses or treatment of disease of any kind.</i></p> <p><i>I understand that massage and bodywork it is provided for the basic purpose of relaxation, relief of muscular tension, connective tissue and rebalancing of the body. If I experience any pain or discomfort during any session, I will immediately inform the practitioner so that the work may be adjusted to my level of comfort. I further understand that all work should not be construed as a substitute for any kind of medical exam, diagnosis, adjustments, or treatment of any kind for physical, mental or emotional condition; and nothing said in the course of any session given should be construed as such. Because bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions accurately, completely, and honestly. I agree to keep the massage/bodywork practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. I understand that I am having work done at my own risk and hereby release Michelle McKusick and Valeo Health & Wellness, LLC from any liability. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.</i></p> <p><i>The therapist is a facilitator for my own (or my child's) personal growth and understanding of that which has blocked forward progress in the desired goals of the client. I understand that I may be given home assignments to further strengthen the work I've done during a session. I take full responsibility for my personal development, whether the challenges have been physical, emotional, mental, energetic, and/or spiritual.</i></p> <p>Client Signature / Guardian Signature (for clients under the age of 18): _____</p>

Health History Information

I have stated all conditions that I am aware of and this information is true and accurate. I will inform Michelle of any changes in my health status going forward.

Signature _____ Date _____