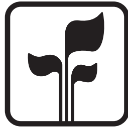


Galter LifeCenter
Part of NorthShore

5157 N. Francisco Ave.
Chicago, IL 60625
773-878-9936
773-907-7486 (fax)
GalterLifeCenter.org

CLINICAL MASSAGE THERAPY CLIENT HEALTH HISTORY

Your confidential health history is being requested for your health and safety. Clinical Massage Therapy affects a variety of body systems. Your response on the following questions will help us create a safe session for you. In some cases, certain health conditions may require adaptation of application and/or a health care provider's release. Your cooperation and understanding is appreciated.

____
NAME | PRONOUNS | DATE

____
ADDRESS

____
EMAIL ADDRESS | DATE OF BIRTH

____
TELEPHONE (BEST NUMBER) | TELEPHONE (ALTERNATE)

____
OCCUPATION

____
EMERGENCY CONTACT (RELATIONSHIP) | CONTACT TELEPHONE

Are you currently under the care of a physician? ❑ Yes ❑ No

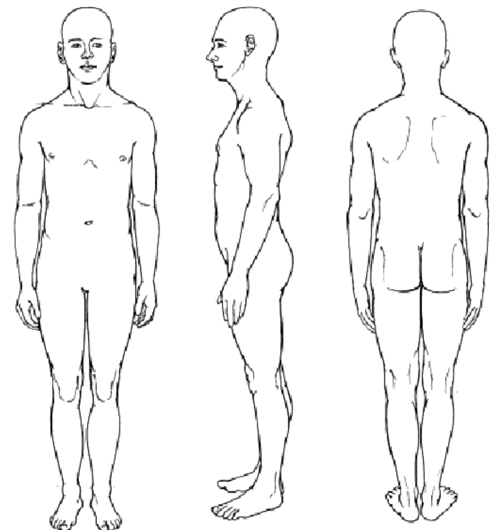
If yes, please indicate your condition: ______________________________

Physician's name: ____________________ Telephone: ____________________

Do you wear orthotics our use any aids for mobility. ❑ Yes ❑ No If yes, please describe: ______________

On a scale of 0 (no tension) to 10 (high levels of stress), please indicate the amount of tension in your life: ________

On the figures to the right, please indicate the areas where you carry tension, experience discomfort or hold stress.



What is your reason for today's visit? ____________________

Have you had any accidents? ❑ Yes ❑ No

If yes, please provide details: ____________________

Do you consider yourself fully recovered? ❑ Yes ❑ No

Have you been hospitalized in the past two years? ❑ Yes ❑ No

If yes, please indicate condition: ____________________

Are there any areas you do not want addressed during your session?

____

Do you take any medications/herbs (prescription or over-the-counter)? ❑ Yes ❑ No

Please list: ____

General Medical Information

For your safety, our therapists must be aware of any history of the following medical conditions. Please indicate if you have ever experienced any of the following:

MUSCULOSKELETAL
- ❑ Fibromyalgia
- ❑ Myofascial Pain Syndrome
- ❑ Spasms/Cramps
- ❑ Sprains/Strains
- ❑ Osteoporosis
- ❑ Postural Deviations
- ❑ Gout
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Disc Herniation
- ❑ Bursitis
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Torticollis
- ❑ Whiplash Syndrome
- ❑ Carpal Tunnel Syndrome
- ❑ Sciatica
- ❑ Thoracic Outlet Syndrome
- ❑ Headache
- ❑ Shin Splints
- ❑ Jaw Pain or Clicking
- ❑ Other

NERVOUS SYSTEM
- ❑ ALS
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Bell's Palsy
- ❑ Neuritis
- ❑ Spinal Cord Injury
- ❑ Trigeminal Neuralgia
- ❑ Seizure Disorders
- ❑ Numbness/Tingling
- ❑ Dizziness
- ❑ Anxiety/Depression
- ❑ Addiction
- ❑ Diagnosed Mental Illness
- ❑ Other

DIGESTIVE
- ❑ Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ Acid Reflux
- ❑ Crohn's Disease
- ❑ Diarrhea
- ❑ Gas/Bloating
- ❑ Indigestion
- ❑ Other

SKIN
- ❑ Bruise Easily
- ❑ Scar Tissue
- ❑ Dermatitis/Eczema
- ❑ Psoriasis
- ❑ Open Wound or Sore
- ❑ Rashes
- ❑ Infectious Condition
- ❑ Allergies or Sensitivities
- ❑ Other

CIRCULATORY
- ❑ Anemia
- ❑ Hemophilia
- ❑ Hypertension
- ❑ Low Blood Pressure
- ❑ Raynaud's Disease
- ❑ Varicose Veins
- ❑ Heart Condition
- ❑ Blood Clots/Phlebitis
- ❑ Diabetes
- ❑ Stroke
- ❑ Swollen Ankles
- ❑ Other

RESPIRATORY
- ❑ Pneumonia
- ❑ Sinusitis
- ❑ Asthma
- ❑ Difficulty Breathing
- ❑ Wheezing
- ❑ COPDs
- ❑ Other

OTHER
- ❑ Insomnia
- ❑ Sleep Apnea
- ❑ Anxiety/Panic Attacks
- ❑ PMS
- ❑ Edema
- ❑ Postoperative Situation
- ❑ Cancer (current or historical)
- ❑ Bladder Infection
- ❑ Chronic Fatigue
- ❑ Kidney Disease
- ❑ Autoimmune disorders
- ❑ Diabetes
- ❑ Allergies ________________
- ❑ Other ___________________

❑ I have no history of any of the above conditions

Are you pregnant? ❑ Yes ❑ No Due date? ____________________ Are you receiving prenatal care ❑ Yes ❑ No

If yes, are you experiencing any of the following?

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Low weight gain
- ❑ High weight gain
- ❑ Protein in urine
- ❑ Visual disturbances
- ❑ Systemic edema
- ❑ Diagnosed maternal illness
- ❑ Multiple gestations
- ❑ Violent headaches
- ❑ Severe vomiting
- ❑ Frequent urination
- ❑ Pelvic pain
- ❑ High blood pressure
- ❑ Excessive hunger or thirst
- ❑ Cramping or contractions

Habits / Lifestyle

What physical activities do you do on a daily or weekly basis? ____

Hobbies? ____

Do you: Smoke? ______________/day Drink? ______________/week Consume caffeine? ______________/day

---

I understand and agree to the following:

All the information I have provided is correct and current to the best of my knowledge, and I will update my health history form with any changes in my health and medications.

Signature ____ Date _____________________________

Parent/Guardian Signature _______________________________ Date _____________________________

Galter LifeCenter
Part of NorthShore

THERAPIES OFFERED

Our clinical massage therapists are licensed and trained to tailor their treatment sessions for wellness and medically based populations. Each session is customized to meet the needs, concerns, and circumstances of each individual. Your therapist may use any one of the following techniques. Other techniques not listed may be used, but your therapist will inform you of any additional techniques, and ask permission before proceeding.

- **Trigger Point/Neuromuscular**: Examines and treats muscles and muscle attachments in layers. It addresses surface muscles, deeper ligaments and connective tissues.

- **Sports/Deep Tissue**: Releases chronic patterns of tension in the body through slow strokes and deep finger pressure on the contracted areas, either following or going across the fibers of the muscles, tendons and fascia.

- **Scar Massage**: Focuses on scar tissue release and fascial restrictions. This is very effective for post-surgical health conditions.

- **Postural Assessment/Posture Program**: This assessment examines your postural deviations and muscular skeletal imbalances with clinical massage therapy treatment recommendations utilizing a posture grid.

- **Myofascial Release**: This is an effective hands-on technique that provides sustained pressure into myofascial (or connective tissue) restrictions to eliminate holding and bracing patterns, decrease pain and restore range of motion.

- **Swedish Massage**: One of the most popular types of wellness massage techniques. It is designed to relieve stress and tension by incorporating long gliding strokes and muscle kneading.

- **Thai Massage:** An interactive manipulation of the body using passive stretching and gentle pressure along energy lines. These movements help to adjust the skeletal structure, increase flexibility, relieve muscular/joint tension, stimulate internal organs and balance the body's energy system. Muscle compression, joint mobilization and acupressure are also used during treatment. Clients wear loose clothing and treatment can be given on a floor mat or table.

- **Zen Shiatsu**: Japanese bodywork that works with meridians/pathways in the body that channel the qi or life force energy. Stagnation can manifest in physical, psychological or emotional imbalances. This treats the whole meridian system through pressure and stretching. Clients wear loose clothing and treatment can be given on a floor mat or table.

- **Manual Lymphatic Drainage**: Manual Lymphatic Drainage is a gentle form of massage that works to encourage the natural functions of the lymphatic system. Through specific, researched techniques, with well documented results, Manual Lymphatic Drainage can decrease swelling, improve the immune system, and speed recovery from injuries and surgeries. It can also help with lymphedema.

- **Pre/Postnatal**: Addresses the needs of expectant and new mothers. Relieves lower back pain, encourages comfortable sleep and balances hormones by promoting increased circulation during this special time.

- **Reflexology:** A technique where pressure is applied to reflex areas on the feet and hands that correspond to all body parts. This technique stimulates the body's potential to heal itself, which can particularly benefit individuals with mild health concerns, severe concerns and degenerative health conditions. During a session, you often experience a release of stress, improved circulation and improved nerve impulses.

- **Watsu:** A passive form of aquatics therapy that incorporates principles of Zen Shiatsu in our heated therapy pool. Watsu is great for relieving mental and physical stress, increasing range of motion, improving circulation, and much more.

Galter LifeCenter
Part of NorthShore

INTEGRATIVE THERAPY CLIENT POLICIES AND PROCEDURES

I understand and agree to the following:

General Policies for the Therapy Session.

1. Integrative therapy is primarily for stress reduction, relief from muscular tension, pain reduction, general relaxation and improvement of circulation;
2. The integrative practitioners do not diagnose illness, disease, or physical or mental disorders and do not prescribe medical treatments or pharmaceuticals, nor do they perform spinal manipulations;
3. Integrative therapy is not a substitute for medical treatment and it is recommended that I see a physician for any physical ailment that I might have;
4. All the information I have provided is correct and current to the best of my knowledge, and I will update my health history form with any changes in my health and medications;
5. If I have a condition that is contagious (such as impetigo, pink eye, athlete's foot) I will inform the therapist before the session. If preventative accommodations to protect the practitioner and other clients cannot be made, the practitioner reserves the right to cancel the session.
6. Any information provided by the practitioner is for client educational purposes only and is not prescriptive or diagnostic in nature;
7. I am encouraged to state my preferences and requests to the practitioner, so that the practitioner may develop an effective treatment plan for my session. I understand that it is important for me to communicate my preferences during the session as well, in order to allow the practitioner to adjust any aspect of the work;
8. If I experience pain or discomfort during a session, I will immediately inform my practitioner so that the technique may be adjusted for my comfort.
9. Treatments start and end within the scheduled session time including conversations with the practitioners. After the session, the practitioner may follow up by email or phone;
10. I will direct any questions or concerns I have to the practitioner. I am aware that if I feel that the practitioner cannot adequately address my concern, I am encouraged to speak to the Integrative Therapy Department Manager;
11. I will turn my cell phone off while in the treatment space.

Galter LifeCenter has a 24-hour cancellation policy.
If you need to cancel your appointment, contact your practitioner or the Courtesy Desk. Clients who call and cancel with less than 24 hours' notice or do not show up for an appointment and do not call to cancel will be charged for the full session.

For Galter LifeCenter members, I hereby authorize Galter LifeCenter to draw by electronic funds 100% of my session rate from the Galter LifeCenter membership account number for any missed or "no show" appointments without notice, or understand that a series sale will be used. I hereby request and authorize Galter LifeCenter to draw by electronic funds from the Galter LifeCenter membership account number for any appointments cancelled with less than 24 hours' notice. Please sign and date.

Signature: ______________________________ Date: ______________________________
Client's (Representative's) Signature

Galter LifeCenter has a no-gratuity policy.
The best gift you can give is a referral or to come back and see us again.

Galter LifeCenter
Part of NorthShore

INTEGRATIVE THERAPY CONSENT, RELEASE AND INDEMNIFICATION FORM

I understand that Integrative Therapy is provided for stress reduction, relief from muscular tension, general relaxation and improvement of circulation. By signing this consent, I agree to the performance of one or more of the following services or therapies stated below:

- Trigger point/Neuromuscular Therapy
- Sports/Deep Tissue Massage
- Scar Massage
- Postural Assessment/Posture Program
- Myofascial Release
- Swedish Massage
- Thai Massage
- Zen Shiatsu
- Manual Lymphatic Drainage
- Pre/Postnatal Massage
- Reflexology
- Watsu
- Other ___________________________________

I have read the description of the services/therapy and have had an opportunity to ask the therapist questions. I understand that there are risks associated with the services which may include but not be limited to bruising and muscle soreness. I do not expect the therapist to be able to anticipate and explain all risks and complications. I understand that I should not have any of the services performed if I have a contagious condition, such as severe cold or flu, or conditions affecting my skin and bones, such as burns, skin infections, bone fractures or advanced osteoporosis, and I will notify the therapist of any such conditions. This consent applies to all therapists who treat me and the integrative therapies stated above that I receive at LifeCenter on the Green, Inc., (Galter LifeCenter).

From time to time in order to create and provide a safe and effective treatment plan, it may be helpful for my therapist to discuss my health history or my condition with my health care provider including but not limited to my physician, physical therapist or others. I will be provided with a separate authorization for my therapist to discuss my health information with my health care provider and I will notify my health care provider of the same. The information discussed will be shared with me and will otherwise remain confidential.

I understand that there is no implied or stated guarantee of success or effectiveness of the service/therapy being provided to me. I also acknowledge that the above services/therapies are not a substitute for medical care, medical examination or diagnosis.

Consent: I hereby give my consent to receive integrative therapy from Galter LifeCenter. I acknowledge and agree that I am doing so at my own risk, and that my health and safety with respect to integrative therapy are my sole responsibility. I acknowledge that my receipt of the integrative therapy from Galter LifeCenter may result in bodily injury or damages to me. My decision to receive integrative therapy from Galter LifeCenter is voluntary, and I know of, understand, and assume any and all the risks that may occur to me in, on or about the Galter LifeCenter’s premises or as a result of my participation in integrative therapy.

Galter LifeCenter
Part of NorthShore

INTEGRATIVE THERAPY CONSENT, RELEASE AND INDEMNIFICATION FORM

Release: In exchange for receiving integrative therapy from Galter LifeCenter, I, for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge and hold harmless Galter LifeCenter, Swedish Covenant Hospital, their affiliates, directors, officers, employees, personnel, volunteers, and any of their instructors, integrative therapists, agents, or representatives (Releasees") from any and all liability and all injuries, including death, damages or claims relating to or resulting from my receipt of integrative therapy, now or in the future, foreseen or unforeseen. I further release the Releasees from any claim whatsoever on account of first aid treatment, emergency medical services or other services rendered to me during my participation in integrative therapy.

Indemnification: I will indemnify and hold harmless the Releasees from and against all rights, claims, damages, demands, lawsuits, liability, losses, costs and expenses (including reasonable attorneys' fees) arising from or in connection with any injuries to other persons or damage to property caused by or attributed to me.

I expressly agree that this release and indemnification is intended to be a broad and inclusive as permitted by the State of Illinois, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I acknowledge that I have read and understood the consent, release and indemnification provisions set forth above and I agree to such terms.

I also acknowledge receipt of the Integrative Therapy Client Policy and Procedures and agree to comply with them.

Integrative Therapy____

____
Client Name **Signature** **Date**

____
Parent/Guardian Name **Signature** **Date**

____
Therapist Name **Signature** **Date**