Artful Touch PATIENT REGISTRATION DATE__________

Your Basic Information

Name ____

Birth date: _______________________ Age: ___________

Gender Identity (circle): M F O ________________

Phone: ____

Address:_______________________________________

____________________________, _____ ___________

Email: ____

Employer name _________________________________

Position ______________________________________

Whom may we thank for referring you? _________________

Your Bodywork Experience

Bodywork Frequency________________________________

Type____

Likes/Dislikes_____________________________________

How would you like to differ after our session today? Can be an emotion, a sense, a physical goal, a headspace, etc.

____

____

Describe other strategies used to cope with accumulated stress ____

____

____

____

How You're Faring Today

Are you seeking treatment to address a specific problem?

____

____

When did your main symptoms appear?

____

Is the condition worsening? YES NO UNKNOWN

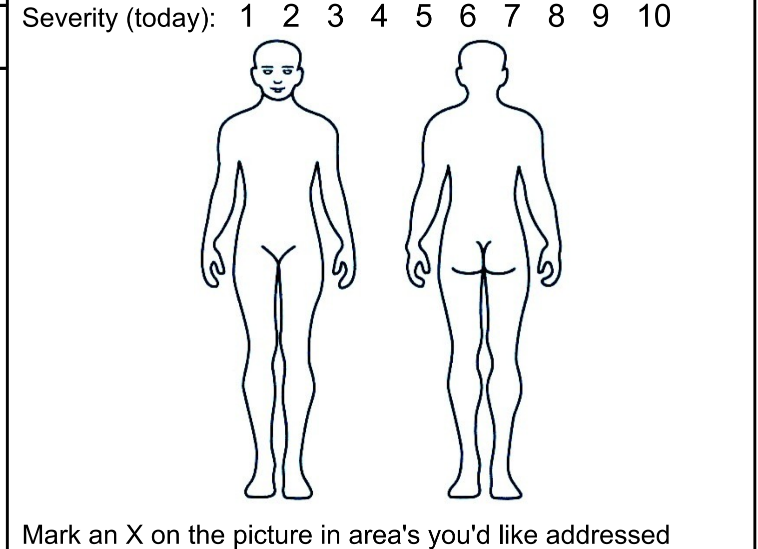
Type of Pain (circle all that apply):

Sharp/Dull	Throbbing	Numbness	Aching
Shooting	Burning	Tingling	Stiffness
Swelling	Cramping	Pins/Needles	Other

How often? ______________________________________

Consistency (circle): Constant Intermittent

Severity (today): 1 2 3 4 5 6 7 8 9 10



Mark an X on the picture in area's you'd like addressed

Injuries/Surgeries you’ve had. These are important and may shed light on current postural issues, even if you don't think they were that bad at the time. Please include fender benders and the like, and injuries in childhood.

	Description	Date
MVA's		
Sprains/Strains		
Head Injury		
Broken Bones		
Dislocations		
Surgeries		
Other		

Artful Touch PATIENT REGISTRATION (Cont'd)

Your Disease History

Please **circle** any which apply to you currently OR mark an “X” if it applies in the past:

AIDS/HIV, Alcoholism, Seasonal Allergies, Anemia, Arthritis___________, Asthma, Bleeding disorders, Bronchitis, Cancer, Diabetes, Eating Disorder___________, Respiratory Disorder __________, Herpes, GI problems ____________, Heart Disease, Chronic Heart Burn/Acid Relfux, Hepatitis, Hernia, Herniated Disk _______, High Blood Pressure, High Cholesterol, Kidney Disease, Liver Disease, Migraines, Multiple Sclerosis, Osteoporosis, Psychiatric Care _____________, Skin Condition or Rash, Stroke, Thyroid Problems, Tumors, Growths, Ulcers Other: ____

Are you on any medications? ____

Any family History of disease? ____

Are you Pregnant? YES NO UNKNOWN When is your due date?_______________________

Your Nutrition and Overall Health

How do you tend to eat? (One huge meal, grazing, etc)____

Staple foods? (3x a week +) ____ Breakfast?_____________________

Height ______________ Weight _________________ Food Allergies____

Vitamins/Supplements ____ Junk foods? __________________________

Do you fall asleep easily? ____________________________________ Stay asleep at night? ______________________

How many average hours?______________________Do you wake feeling rested?______________________________________

How's your water intake? ____ Do you carry a bottle? ________________

Exercise	Work Activity	Fun Habits
___________________________	___________________________	___________________________
■ None	■ Sitting	■ Smoking Packs/day ______________________
■ Light	■ Standing	■ Alcohol Drinks/week ____________________
■ Moderate	■ Light labor	■ Caffeine Cups/day _______________________
■ Insanity!!	■ Heavy labor	■ Sleep aids Nights/week ___________________
		■ High Stress Reason ________________________

* For Artful Touch Use Only *

First Session Observations ____

____

Tx ____ Homework ____

Ideas for future Tx ____

____