

DIW Massage: Client History

Please complete the following before care is considered

Circle all current conditions –AND– all recurrent conditions –AND– all previously diagnosed conditions rendered from a health care provider

Client only	Notes ONLY	Client only	Notes ONLY	Client only	Notes ONLY	Client Only	Notes ONLY
Allergies _____		Shoulder pain _____		Asthma _____		Spitting blood _____	
Chills _____		Elbow / Wrist pain _____		Emphysema _____		Blood in urine _____	
Convulsions _____		Knee / foot pain _____		Deafness _____		Blood in stool _____	
Dizziness _____		Swollen joints _____		Ear noises _____		Freq. urination _____	
Fainting _____		Belching or gas _____		Thyroid disease _____		Diff. holding urine _____	
Fatigue _____		Indigestion _____		Hoarseness _____		Painful urination _____	
Headache _____		Acid reflux _____		Bleeding _____		Prostate disease _____	
Loss of sleep _____		Irritable bowel _____		Easy bruising _____		Painful periods _____	
Weight gain _____		Diarrhea _____		Ear pain _____		Breast implants _____	
Nervousness _____		Excess hunger _____		Chest pain _____		Pregnancy _____	
Nerve pain _____		Jaundice _____		High blood pressure _____		Seizures _____	
Night sweats _____		Hepatitis _____		Low blood pressure _____		Depression _____	
Numbness _____		Liver disease _____		Heart pain _____		Anxiety _____	
Recur. twitches _____		Gall Blad. Disease _____		Heart disease _____		Cancer _____	
Tremors _____		Aids _____		Strokes _____		Diabetes _____	
Difficult breathing _____		Pancreatic disease _____		Ankle swelling _____		Contagious dis. _____	
Neck pain _____		Kidney disease _____		Feet swelling _____		Lupus _____	
Thoracic pain _____		Nausea _____		Varicose veins _____		Multiple Sclerosis _____	
Low back pain _____		Abdominal pain _____		Skin disease _____		Head injury _____	

OTHER HEALTH INFORMATION

Surgeries: Initial here if you have **Never** had any surgeries.

List all surgeries	List all dates	List all surgeries	List all dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Injuries: Initial here if you have **Never** had any injuries.

List all accidents resulting in treatable injuries. Include auto and spinal injuries	List all dates
_____	_____
_____	_____

Spinal History: Initial here if you have **Never** had any non-surgical spinal procedures.

List all non-surgical procedures including spinal taps, injections, braces, etc.	List all dates
_____	_____
_____	_____

List all Medications and Nutritional: Initial here if you **Do not** take medications, nutritional supplements, or herbs

Please list all disease (diabetes, lupus, liver, kidney, cancer, etc.) for:

Your self _____

Your immediate family _____

Do you: Smoke Y N _____ per day Drink alcohol Y N _____ per day Exercise _____ x / week.

Do you have any history of cancer Y N If yes, what type and when _____

By signing below, I agree that I have completed the above and I have not omitted any relevant health information.

Signature of client or guardian _____ Date ____ / ____ / ____

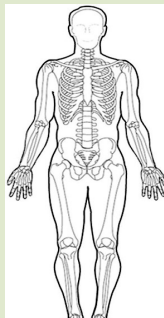
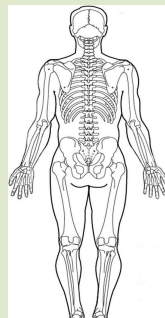
DIW Massage: Treatment Notes

STATE YOUR CURRENT CONDITION, INJURIES, and MEDICAL CHANGES SINCE YOUR LAST VISIT & INITIAL FORM
 Date ___/___/___ Status _____

Initials _____

Date ___/___/___ Status _____

Initials _____

#	Primary complaint severity 0 1 2 3 4 5 6 7 8 9 10	SUBJECTIVE _____		
	Front Back	OBJECTIVE _____		
	P = Pain A = Ache S = Stiff B = Burn Sh=Shooting Sp=Spasm N = Numb T = Tingling	 	ASSESSMENT _____	
	Right Left Left Right	PLAN _____		

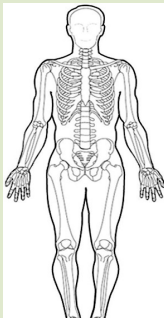
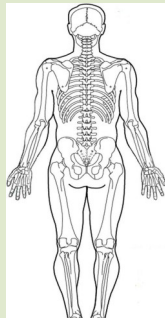
CLIENT NAME:

A = Aggravates R = Relieves	Improved	Intermit	Severe	ACTIVE SPONDYLOGENIC REFLEX
A R Sit A R Bend A R Lying	No Chg	Relapsing	Acute	
A R Stand A R Lift A R Walk	Worse	Constant	Chronic	
A R Move A R Drive A R Work	Flare-up	Positional	Recurrent	

1' _____ 2' _____
Spinal Reflex Therapy (SRT) procedures are utilized for specific Spondylogenic Reflex Syndromes (SRS), associated with the above listed spinal segments. For further reference on current SRS material and research, visit www.spinalreflex.org.

SRA EXERCISES								MARKERS
CARE PLAN	Acute 6-8 wks	Chronic 8-12 wks	Recurrent 4-12 wks	Intermittent 2 wks+ PRN	Preventative Periodic	PRN 3 mo		
M T W T H F	For: 1wk	2 3	4 5	6 7 8	Other: _____			THERAPIST
M W F + S	For: 1wk	2 3	4 5	6 7 8	Other: _____			
T T H + S	For: 1wk	2 3	4 5	6 7 8	Other: _____			

Complications

Primary complaint severity 0 1 2 3 4 5 6 7 8 9 10	SUBJECTIVE _____		
Front Back	OBJECTIVE _____		
P = Pain A = Ache S = Stiff B = Burn Sh=Shooting Sp=Spasm N = Numb T = Tingling	 	ASSESSMENT _____	
Right Left Left Right	PLAN _____		

A = Aggravates R = Relieves	Improved	Intermit	Severe	ACTIVE SPONDYLOGENIC REFLEX
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