

HEALTH HISTORY FORM

Name: _____ Date: _____
Occupation: _____

Do you have specific pain you wish to be treated? Please describe: _____

Are there any activities that are difficult or painful to do? _____

Are you currently under the care of a health practitioner for any reason?
If yes, who and for what purpose? _____

Please list any medications you are currently taking, including skin patches: _____

Please list any recent trauma or injuries: _____

List any surgeries you have ever had and their dates: _____

List any prostheses, pins, bars, implants, etc. _____

What are your most frequent activities involved in at work and home? Sitting Standing Lifting
Other: _____ How much water do you drink per day? _____

Healthy Diet

Adequate Sleep

Sleep Position

Habits

In which part of your body do you feel stress most often?
Other: _____

Is a portion of your day set aside for relaxation, if so what kind? _____

Have you ever had a professional massage before? _____

What are your goals for treatment? _____

Are you pregnant or trying to become pregnant? Y N Are you allergic to any nut oils? Y N

Please Check any illness and/or medical conditions, which you have or have had:

- | | | | |
|---------------|---------------------|----------------------|------------------|
| Allergies | Depression | Infectious condition | Pins and needles |
| Arthritis | Diabetes | Kidney condition | Poor circulation |
| Asthma | Disc problems | Limited movement | Sciatica |
| Blood clots | Edema | Liver condition | Scoliosis |
| Bruise easily | Epilepsy | Low blood pressure | Sinus problems |
| Cancer | Fatigue | Neck pain | Sleep Apnea |
| Carpal tunnel | Fractures | Numbness | Skin disorders |
| Chest pain | Headaches | Osteoporosis | Stroke |
| Chronic cough | Heart condition | Phlebitis | Swollen joints |
| Constipation | High blood pressure | Pinched nerves | Varicose veins |

Please list any other condition that you feel the therapist should be aware of prior to treatment:

CONSENT SIGNED _____



Name: _____ Date: _____ Phone: _____

Address (Please Include City, State & Zip code): _____

E-mail: _____ Referred by: _____

Age: _____ Date of Birth: _____ Occupation: _____

Emergency Contact (Name/Phone): _____

How did you hear about The Center? _____

CONSENT FOR MASSAGE THERAPY

- The unclothed body will be properly draped at all times for your warmth, sense of security, and as a mark of massage professionalism.
- Focused attention and manual therapy will be given as agreed upon by therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and health promotion. My therapist has discussed the potential benefits and possible side effects of this therapy. I have been given the opportunity to ask questions.
- I as client agree to provide complete and accurate health information and notice of health changes at successive appointments as appropriate.
- I understand that massage therapy is designed to be an ancillary health aid and is not intended to be a substitute for primary medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist.
- Written referral is requested from your primary care provider if:
 - 1) You are currently receiving care or
 - 2) You have a specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.
- I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure or strokes may be adjusted to my level of comfort.
- I understand that this professional massage is therapeutic in nature and is performed by a trained, state-licensed therapist.
- I understand that the massage is not sexually oriented in any way and that any illicit or suggestive remarks or behavior on my part will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.
- I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent.
- I have read this form and hereby freely give my permission to receive massage therapy.

Name: _____ Date: _____