Health History Form

Name ____Today's date _____ /_____ /______

Address ____

City ____ State ______________ Zip _______________________

Phone: Work ___________________ Home ____________________ Cell _________________________

E-mail address ____ *May we contact you via e-mail?* Y N

Age________ Date of Birth _____ /_____ /______

Occupation ____

Emergency Contact ____________________ Phone __________________ Relationship ___________________

Referred by ____

Do you pursue any hobbies and/or exercise regularly? Y N If yes, what and how often? ___________________

____

List any surgeries, hospitalizations, accidents or serious injuries, past or present (include dates):

____

____

____

What is your stress level today? (Mark on scale below):

No stress/ relaxed |____| ***Maximum stress***

Are you experiencing any pain today? Y N Please explain____

____

Are you currently being treated by a doctor or another health care practitioner? Y N

If yes, for what condition? ____

Do you currently have: ____Fever ____ A cold ____ Other viral/bacterial infection _____Edema (swelling)

Check all that apply to you (past or present):

___Allergies ___Asthma ___Cancer ___Lymphatic condition ___Gout ___Arthritis ___Strain/Sprain
___Whiplash ___Low back pain ___Tendonitis ___TMJ dysfunction/jaw pain ___Osteoporosis/osteopenia
___Scoliosis ___Broken bones ___Osteoarthritis ___Disc problems/herniated disc ___Bursitis
___Rheumatoid arthritis ___Lupus ___Arteriosclerosis ___Heart disease ___High/low blood pressure
___Phlebitis ___DVT ___Clotting disorders ___Anemia/bruise easily ___Varicose veins ___Diabetes
___Peripheral neuropathy ___ Numbness/tingling ___Pinched nerves ___Carpal tunnel syndrome
___Sciatica ___Fibromyalgia ___Dizziness ___Headaches/Migraines ___ Multiple Sclerosis
___Parkinson's ____Mononucleosis ___Shingles ___Impetigo ___Warts ___Athlete's foot
___Skin disorders ___Fatigue ___Frequent constipation ___Other (specify) __________________________

Please check medications you are currently taking (including over the counter and supplements):

___Blood pressure meds ___Blood thinners ___Muscle relaxants ___Pain killers
___Anti-inflammatories ___ Anti-depressants ___Cortisone injections
___Other (please list) ____

What is the primary reason you are getting a massage today? ____

____

Have you received professional massage before? Y N If yes, how often? ____________________________

Do you have allergic reactions to oils, ointments, lotions, or to any nuts? Y N

Please explain ____

____

Do you wear contact lenses? Y N Do you wear prosthetics? Y N

For women: Are you pregnant? Y N If yes, what week: ___________________

Scope of Massage Therapy Practice

Massage is a form of bodywork that dates back more than 3,000 years. It involves the manipulation of tissue through touch to promote a client's well-being and health. The benefits of massage therapy include relief of muscle tension and pain, relaxation, increased energy, reduction of stress and anxiety, improved circulation, digestion, immunity, flexibility, breathing, posture, and a greater sense of the mind-body-spirit connection. The massage therapy session is an experience jointly created by the therapist and the client. We will listen and respond to your words and to the tissues in your body to create a safe, healthy and healing session for you.

Massage therapy is not a substitute for medical care or counseling, and we do not diagnose, prescribe medications, or give advice with regard to medical conditions. If you are experiencing a condition that contraindicates massage, we may refer you to another healthcare provider.

Ethics & Privacy

Our massage practice is strictly non-sexual. Any behavior that might be interpreted as sexual in nature will result in immediate termination of the session without refund of the session fee. We follow the guidelines of privacy of information according to the April 2003 privacy act (HIPPA). All information shared during the session is strictly confidential.

Cancellation Policy

"No-shows" or appointments cancelled less than 24 hours in advance will be charged the full fee, unless you are ill or have an emergency. If you arrive late, we will still have to end at the scheduled time, resulting in a shorter session. All returned checks incur a fee of $25.

Informed Consent

I acknowledge that the information I provided in this form is complete and accurate. I stated all my known medical conditions and medications, and will inform the massage therapist of any changes in my health status. I understand the information provided is strictly confidential. I also understand the scope of massage therapy practice and the policies listed above.

Signature ____Date _____ /_____ /______