

HEALTH HISTORY

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or symptoms, massage/bodywork may be contraindicated.

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

Y N Was it beneficial? Comments: _____

Y N Are you pregnant? If yes, how far along are you? _____

Y N Are you sensitive to touch/pressure in any area? (ticklish?) _____

Y N Do you have any allergies? If yes, please list: _____

Y N Do you like essential oils?

In general, what type of pressure do you prefer? (please circle) Light / Medium / Deep

Are there areas you DO NOT wish to receive therapeutic massage? _____

Are you wearing: Y/N Contact lenses? Y/N Dentures? Y/N Hearing aid? Y/N Other _____

How would you describe your overall stress level? (please circle) Low/ Moderate/ High

Comments _____

How do you think it has affected your health? (please circle) Muscle tension/ Anxiety/ Insomnia/
Irritability/ Other: _____

Please indicate the following use with: **H**- heavy, **M**- moderate, **L**- light, or **N**- none

Alcohol _____ Caffeine _____ Tobacco _____ Sugar _____

How much water do you consume each day? Less than 1 Liter _____ 1 Liter _____ 2 Liter _____ Other _____

How many hours do you sleep each night? _____ Do you sleep on your: Side _____ Back _____ Stomach _____

List of surgeries (type and date): _____

Reason for today's visit _____

If you have an injury or condition you want addressed today, when and how did your symptoms begin?

Does it interfere with: Work _____ Sleep _____ Daily routine _____ Recreation _____

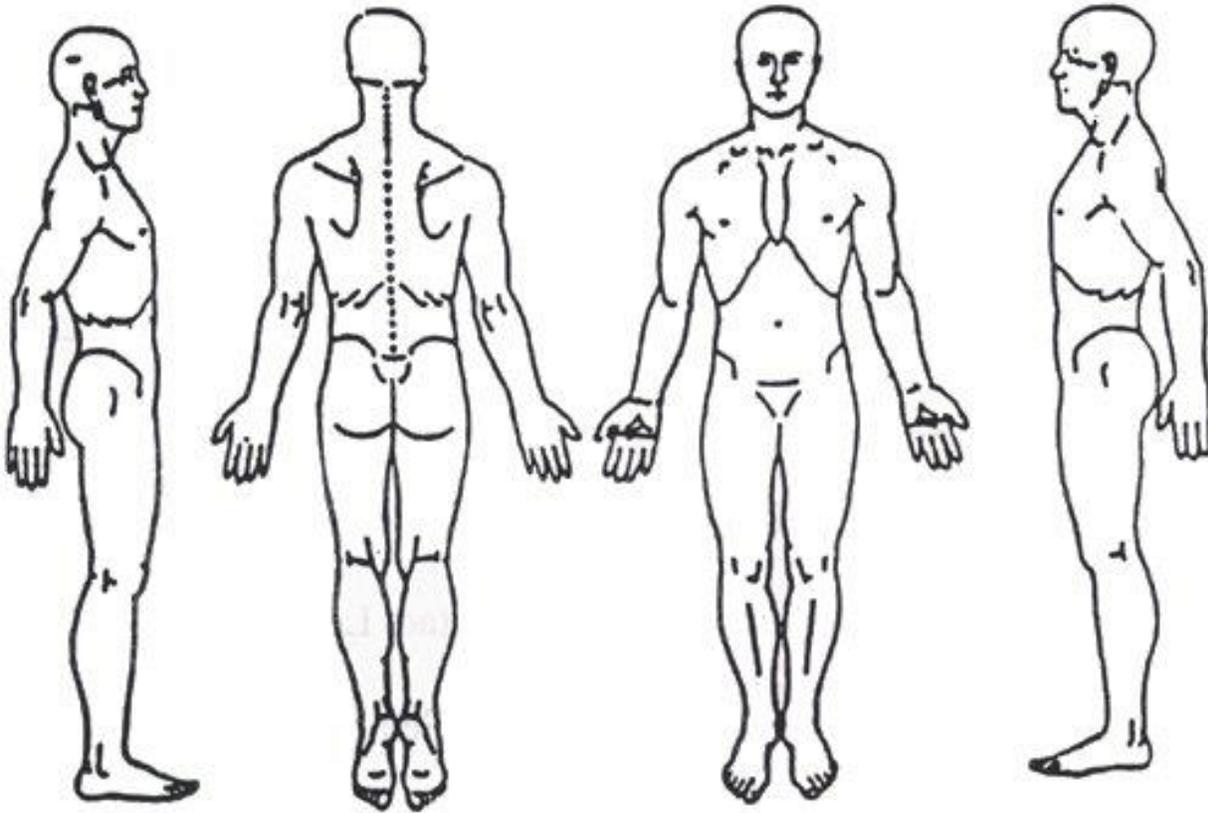
What have you done for relief? _____

Is it getting better/ worse? Comments: _____

Please check all that apply:

- Recent injury or accident: whiplash/ sprain/ bruise/ other _____
- Skin condition: fever blister/ herpes/ rash/ warts/ hives/ skin cancer/ other _____
- Foot or toenail fungus: athletes foot/ yellow toenails/ red or cracked skin/ other _____
- Joint problems: stiffness/ arthritis/ TMJ/ tendonitis/ bursitis/ other _____
- Bone condition: osteoporosis/ fracture/ other _____
- Circulatory condition: high blood pressure/ low blood pressure/ varicose veins/ blood clots
- Lymphatic condition: swollen gland/ nasal congestion/ lymph edema
- Nerve condition: numbness/ tingling/ sharp-shooting pain/ sciatica/ other _____
- Circle any of the following that apply: AIDS- HIV/ Cancer/ Contagious Disease/ Depression/ Diabetes/ Epilepsy/ Fibromyalgia/ Frequent headaches/ Heart condition/ Hepatitis/ Herniated disc/ Lupus/ Migraines/ Multiple sclerosis/ Parkinson's disease/ Stroke/ Other _____

Please indicate areas where you have pain or tension:



MASSAGE INFORMED CONSENT

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or techniques may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any mental or physical illness, and that nothing said in the course of the session given should be construed as such. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____

Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____
To administer massage/bodywork techniques to my child or dependent as they deem necessary.

Signature of Parent/Guardian _____

Date _____