Health Information Form

Name _____ **Phone** _____

Address _____

City/State/Zip _____

DOB _____ **Email** _____

Occupation _____

Primary Physician _____ **Phone** _____

Emergency Contact _____ **Relationship** _____

Phone _____

How did you hear about us? _____

Have you had a professional massage before? ☐ Yes ☐ No

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

What are **YOUR** goals for this treatment session? _____

_____

Are you taking **any medications**? ☐ Yes ☐ No

If yes, please list name and use: _____

_____

_____

_____

Do you suffer from **chronic pain**? ☐ Yes ☐ No

If yes, please explain. _____

_____

What makes it **better**? _____

What makes it **worse**? _____

Have you had any **orthopedic injuries**? ☐ Yes ☐ No

If yes, please list. _____

_____

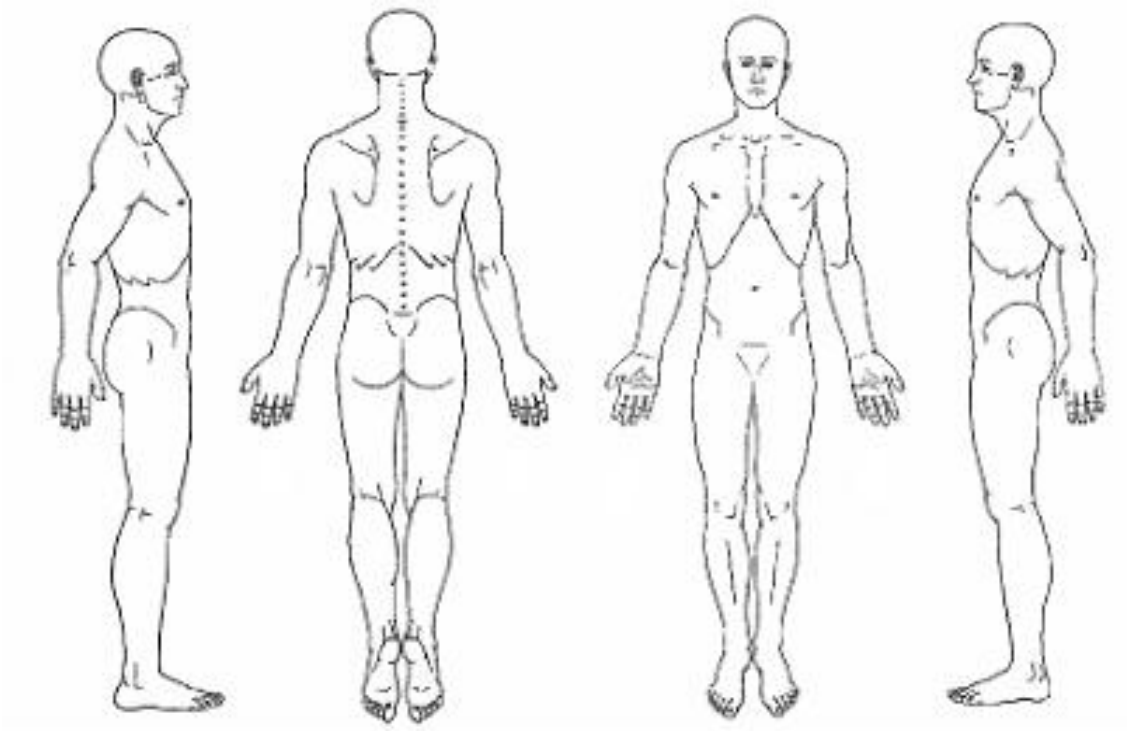
Health Information Form

Please indicate any of the following that apply to you and explain. This info is necessary for your safety, as massage may not be indicated for some of these conditions.
If you are unsure, please ask. Thank you so much.

1. Arthritis (RA, Osteo) _____
2. Asthma _____
3. Blood clots _____
4. Blood Pressure (High / Low) _____
5. Broken Bones, Sprains or Strains _____
6. Bruise easily _____
7. Cancer _____
8. Depression, Anxiety _____
9. Diabetes _____
10. Digestive Conditions (Chron's IBS) _____
11. Epilepsy, seizures _____
12. Fibromyalgia _____
13. Headaches/migraines _____
14. Heart Attack _____
15. High/low blood pressure _____
16. Joint replacement(s) _____
17. Kidney Dysfunction _____
18. Neurological (e.g., MS, Parkinson's) _____
19. Neuropathy _____
20. Numbness _____
21. Scoliosis _____
22. Scoliosis _____
23. Stroke _____
24. Swelling / Edema _____
25. Thyroid/Endocrine Conditions _____

Health Information Form

Please circle any areas of discomfort.



Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage/bodywork 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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date:_____
(In case of a minor)