Health Information Form

Client Contact Information:

Client Name: _____

Date of Birth: _____

Address:

_____

Phone: _____ Email: _____

Emergency contact: _____ Phone: _____

Physician/Health-care Provider name: _____

Phone: _____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes □ No □

Do you have a physician referral/prescription? Yes □ No □

Massage Information:

Have you ever received professional massage/bodywork before? Yes □ No □

How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

_____

_____

_____

_____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No Explain:

_____

_____

List the medications you currently take:

_____

_____

Health History

Are you fully COVID-19 vaccinated? Yes No
Have you had any injuries or surgeries in the last 12 months? If so, please describe__
_____
_____
_____

Please circle any of the following health conditions that you currently have (if you are unsure,please ask). Please answer honestly, as massage may not be indicated for the following conditions. Thank you.

- blood clots
- infections
- congestive heart failure
- contagious disease
- pitted edema

Please indicate conditions that you have or have had in the recent past. Please explain in detail, including treatment received:

Current Past Muscle/joint pain_____
Current Past Muscle/joint stiffness_____
Current Past Numbness or tingling_____
Current Past Swelling_____
Current Past Bruise easily_____
Current Past Sensitive to touch/pressure_____
Current Past High/Low Blood Pressure_____
Current Past Stroke/Heart Attack_____
Current Past Varicose veins_____
Current Past Shortness of breath/Asthma_____
Current Past Cancer_____
Current Past Neurological illness_____
Current Past Epilepsy, seizures_____
Current Past Headaches, Migraines_____
Current Past Dizziness, ringing in the ears_____

Current Past. Digestive conditions (i.e. Crohn's)_____
Current Past Gas, bloating, constipation_____
Current Past Kidney disease/infection_____
Current Past Arthritis (rheumatoid, osteoarthritis)_____
Current Past Osteoporosis/degenerative spine/disk_____
Current Past Scoliosis_____
Current Past Broken bones_____
Current Past Allergies_____
Current Past Diabetes_____
Current Past Endocrine/thyroid condition_____
Current Past Depression, anxiety_____
Current Past Memory loss/confusion_____

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 further 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 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 understandthat there shall be no liability on the practitioner'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.

I also understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto.

Understanding all of this, I give my consent to receive treatment from this practitioner.

Client Signature:

_____

Date: _____

Parent or Guardian Signature (in case of a minor):

_____ Date: _____