# HEALTH HISTORY FORM

*An accurate Health History is important to ensure that it is safe for you to receive Massage Therapy treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is kept confidential except as required or allowed by law or to facilitate diagnosis and treatment with an accredited medical professional. You will be asked to provide written authorization for release of any information.*

## PERSONAL INFORMATION

Date ___________________________

Name ______________________________________________________________
First                                  Initial                                  Last

Address ______________________________________________________________
Street                                  Apt.          City          State          Zip Code

Home Phone: (____) ______________ Bus. Phone: (____)________________ Cell Phone :(____)________________

Email ___________________________________ Would you like to receive newsletters and updates via email? O Y O N

Birth Date: (dd/mm/yyyy) ____________________________ Age: ___________________ Sex: O Male O Female

Physician: ______________________________________________________________
Name                                  Phone                                  Date of Last Visit

Name and Number of Emergency Contact: ______________________________________________

Referred to us by? ______________________________________________________________

Business/Employer: _________________________________________ Health Plan: ___________________________

Occupation: ______________________________________________ Hours per Day: ___________________________

Type of Exercise/Activities: __________________________________ Frequency: _____________________________

Previous Massage Experience? O Yes O No Frequency ___________________ Purpose: ___________________

## CURRENT HEALTH STATUS

Rate your general Health Status: (*please circle*): 1 2 3 4 5 6 7 8 9 10
(1 Poor, 4 Fair, 7 Good, 10 Excellent)

Rate your level of Stress: (*please circle*): 1 2 3 4 5 6 7 8 9 10
(1–2 Negligible, 5–6 Moderate, 9–10 Extreme)

**Current Medications** *(including supplements)*

| Name | For what condition? |
|---|---|
| | |
| | |
| | |
| | |

**Other Healthcare**

- O Chiropractic
- O Physical Therapy
- O Psychotherapy
- O Acupuncture
- O Other: ______________________

Have you taken/used any medication in the last 24 hours that could alter your sensations (pain medications, muscle relaxant, etc.) O Yes O No If Yes, please list: ______________________________________________

Name:

***Please check (✓) any conditions below that you are currently experiencing or have experienced often in the past:***

**Respiratory:**
- O Asthma
- O Shortness of Breath
- O Chronic Cough
- O Bronchitis / Emphysema
- O Smoking
  Are you open to support for quitting?
  OYes ONo

**Cardiovascular:**
- O High Blood Pressure
- O Low Blood Pressure
- O Heart Disease
- O Heart Attack/Stroke
- O Poor Circulation
- O Varicose Veins/Phlebitis
- O Reynaud's Disease
- O Bruise Easily

**Muscular-Skeletal:**
- O Spasm / Cramps
- O Broken/fractured bones
- O Sprains / Strains
- O Scoliosis
- O Jaw Pain / TMJ
- O Tendinitis / Bursitis
- O Thoracic Outlet Syndrome
- O Osteoporosis
- O Painful/Stiff Joints
- O Arthritis; Osteo or Rheumatoid?
- O Other: ____________________

**Infectious:**
- O Herpes
- O Warts / Skin Conditions
- O HIV/Aids
- O Tuberculosis (TB)
- O Other: ________________

**Head / Neck:**
- O Whiplash
- O Vision loss/eye problems
- O Hearing loss/ear problems
- O History of Headaches
  Type: __________________
  Frequency: ______________
  Location: _______________
- O History of Migraines
- O Neck Pain

**Digestive:**
- O Indigestion/Abdominal Pain
- O IBS
- O Constipation
- O Diarrhea
- O Crohn's Disease
- O Colitis
- O Liver: __________________
- O Gallbladder: _____________
- O Other: _________________

**Nervous System:**
- O Numbness / Tingling
  Location: _______________
- O Cerebral Palsy
- O Paralysis
- O Epilepsy
  Triggers: _______________
  Frequency: ______________
- O Parkinson's disease
- O Spinal Cord Injury
- O Loss of sensation
  Location: _______________

**Women:**
- O Pregnancy
  Due date: ______________
- O Caesarean or other Gynaecological Surgeries
- O Menopause
- O PMS
- O Endometriosis
- O PID
- O Fertility Concerns
- O Painful Menstruation

**Skin:**
- O Rash
- O Athlete's Foot
- O Warts
- O Cosmetic Surgery
- O Other: __________________

**Other:**
- O Diabetes
- O Cancer
- O Multiple Sclerosis
- O Sensitive Skin / Aversion to Heat
- O Dementia / forgetfulness
- O Fibromyalgia
- O Fatigue
- O Lymphedema
- O Artificial joints/pins
- O Insomnia
- O Post/Polio Syndrome
- O Depression
- O Other: _________________

**Allergies:** *(please list, include sensitivities to lotions and detergents)*

____________________________________________________________

____________________________________________________________

**Injuries**

Type: ____________________________________________________________

Date: ____________________ Current Symptoms: ______________________________

Type: ____________________________________________________________

Date: ____________________ Current Symptoms: ______________________________

**Surgeries:**

Type: ____________________________________________________________

Date: ____________________ Current Symptoms: ______________________________

Type: ____________________________________________________________

Date: ____________________ Current Symptoms: ______________________________

Name:

Please explain any item checked on page 2: ______________________________

______________________________

## CURRENT HEALTH COMPLAINT

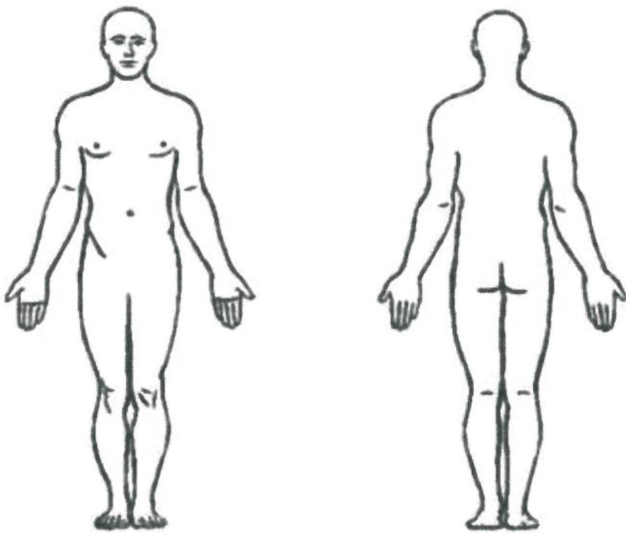
What is your primary reason for seeking Massage Therapy? ______________________________

Have you had this condition in the past: ○Yes ○ No If yes, was it resolved? ______________________________

What makes this condition worse? ______________________________ Better? ______________________________

Please Rate the intensity of your discomfort: (*please circle*): 1 2 3 4 5 6 7 8 9 10

**No pain** **Moderate** **Intolerable**



*Please illustrate:* **X** *areas of pain* ⸗ *areas of tingling (pins and needles)* ✔ *areas of no symptoms*

How often do you feel this?

○It comes and goes ○ Frequently ○ Constantly

How would you describe muscle/ joint discomfort?

○Sharp ○Dull ○Burning ○Achy ○Throbbing

○ Pins and needles ○other: ______________________________

This discomfort is effecting your:

○ Work ○Activity/Sports ○Home Life ○Sleep

Any other information you would like to share?

______________________________

______________________________

______________________________

______________________________

## CONTEXT OF CARE REVIEW

Why did you choose to come to this clinic?

What expectations/goals do you have for the initial visit?

What long-term expectations/goals do you have about Massage Therapy?

Name:

## POLICIES & CONSENT

**Policies/Information:**

- Payment in full is expected at time of services rendered.
- Appointments cancelled with less than 24 hours notice are to be paid in full.
- Massage Therapy, Energy work (such as Reiki), or other modalities offered, is not a substitute for medical or psychological diagnosis and treatment. Referrals may be made for such treatments which are beyond the scope of Massage Therapy practice.
- I understand that I have the right to refuse, alter, or terminate treatment at any time; I may also rescind consent at any time.
- I understand that many techniques used during treatment may cause discomfort or pain that may last beyond the scheduled session.
- Should any contact information, health status or medications change in the future I will make these changes known to my Therapist. All information will be updated yearly.
- Requests for services of a sexual or inappropriate nature are not tolerated and may result in legal action.

**Contract for Care:**

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my Massage Therapist and other members of my health care team. I agree to participate in the self-care program that we select. I promise to inform my health care team any time I feel my well-being is threatened or compromised. I expect my Massage Therapist to provide safe and effective treatment.

**Consent for Care:**

It is my choice to receive Massage Therapy, and I give consent for treatment. I understand that Massage Therapists DO NOT diagnose illness, disease, or other physical or mental disorders. Massage Therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's or clinic's part should I neglect to do so.

I, the undersigned, agree that to the best of my knowledge all above information is current and accurate. I am satisfied that I fully understand the nature of the sessions and freely elect to receive treatments. Having read, understood, and agreed to the above, I do hereby release *Mind Your Body* and its Therapists from any and all claims of adverse reactions or conditions that I feel may be a result of this treatment now and at any time in the future. I participate in this therapy completely at my own risk, and do so knowingly.

Signature: ______________________________ Date: ____________________

Signature of parent/guardian: ______________________________ Date: ____________________
*(If client is a minor)*