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Client Health History Form

Please print clearly and complete both pages of this form. This information is critical to your treatment as it may affect the manner in which your session is structured. All information disclosed will be kept strictly confidential.

Name:_____ Date:_____

Home phone: _____ Work phone: _____ Cell phone: _____

_____

Address street city state ZIP code

Email address(es): _____

Occupation: _____ Male/Female Date of Birth: _____

Referred by: _____

Emergency contact: _____

Have you ever had a therapeutic massage before? **Yes No Many Times**

What physical activities do you do on a weekly basis? _____

Please circle areas where you are feeling discomfort at this time:

Head / face	Low back	Shoulders	Neck	Abdomen
Legs / feet	Arms / hands	Mid-back	Other: _____	

Do you take any medications or drugs that alter sensation? (e.g., pain medications, muscle relaxants, alcohol or other depressants or stimulants.) These may affect the therapist's choice of techniques: _____
_____

Please circle any of the following health issues that you have had *in the past year*.

Allergies: _____

Angina	Fibromyalgia	Insomnia	Stroke
Asthma	Heart disease	Kidney/Urinary	Surgery
Athlete's Foot	Hepatitis	Migraines/Headaches	Varicose veins
Blood clots	Herpes simplex	Phlebitis/Thrombosis	Whiplash
Cancer	Hospitalization	Pregnancy	Other:
Depression	Hypertension	Repetitive Strain Injuries	
Disk problems	Irritable Bowel Syndrome	Sciatica	

Other: _____

Please continue to second page

Symptom	Yes	No	Location (describe)
Any areas of infection?			
Any areas of swelling, edema, or tendency to swell?			
Any areas of numbness or altered sensation?			
Any areas of pain or tenderness?			

For your safety, your therapist must be aware of all medical conditions. Therapeutic massage may affect these and your health:

Condition	Yes	No	Please Describe
Arthritis:			
Cancer or Tumors:			
Cardiovascular Disease:			**Please circle all that apply**: Anemia, Angina, Arteriosclerosis, Congestive Heart Failure, Heart Attack, Heart Murmur, Hemophilia, Hypertension, Varicose or Spider Veins, Other:
Diabetes:			
Injuries:			
Kidney, Liver, or Urinary Problems:			
Respiratory Conditions:			
Skin Conditions:			**Please circle all that apply:** Acne, Abrasions/Cuts, Birthmarks/Moles, Bruises, Dermatitis, Eczema, Herpes, Hives, Poison Ivy/Oak/Sumac, Psoriasis, Skin Tags, Sunburns, Warts, Other: _____
Surgery:			**Date of Surgery(s):** **Describe:**
Gastrointestinal Problems:			
Other Medical Conditions not mentioned above:			**Please describe:**

Client Consent and Waiver

I understand that I will be asked questions regarding my physical state including present condition as well as past medical history. I understand that there are certain medical conditions for which massage therapy would be contraindicated and that I may need to obtain written permission from my physician before receiving treatment. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I am concurrently working with my Primary Caregiver for any condition I may have. I verify that all information provided is correct and current to the best of my knowledge and will keep the therapist updated on any changes.

All information disclosed will be kept strictly confidential by the therapist. I give my consent to receive therapeutic massage and will not hold my therapist, Megan Belanger, LMT, CLT responsible for any personal injury or loss of property. I am aware that the massage therapist does not diagnose illness or disease, nor prescribe medications or supplements. I understand that payment is due at the time of service. Appointments that are canceled within 24 hours of the scheduled session will result in a charge for the full price of the treatment session scheduled. Emergency cancellations may be determined at the therapist's discretion. Thank you and enjoy!

Signature:_____ Date:_____

Print Name:_____