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## Confidential Health History

Name \_\_\_\_\_ Date \_\_\_\_\_  
LAST FIRST M.I.

Address \_\_\_\_\_  
STREET CITY STATE ZIP

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address \_\_\_\_\_

How did you hear about me? \_\_\_\_\_ May I add you to my mailing list? Y or N

Have you ever had massage or bodywork before? Y or N If so, how often? \_\_\_\_\_

What, if any, exercise do you do? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Are you currently taking any medications? Y or N For what? \_\_\_\_\_

Have you ever broken a bone? Y or N If yes, please explain \_\_\_\_\_

Have you ever had surgery? Y or N If yes, please explain \_\_\_\_\_

What are the current stresses in your life? \_\_\_\_\_

Do you have any of the following?

(Please check all that apply. Please use the back of this sheet to provide further information.)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Contact Lenses       | <input type="checkbox"/> Low back pain      | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> Allergies/Sinus      | <input type="checkbox"/> Neck Pain          | <input type="checkbox"/> TMJ                     | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Chronic Pain       | <input type="checkbox"/> Grind Teeth             | <input type="checkbox"/> HIV              |
| <input type="checkbox"/> Dizziness/Fainting   | <input type="checkbox"/> Pain with Movement | <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Herpes           |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Loss of Movement   | <input type="checkbox"/> Varicose Veins          | <input type="checkbox"/> Chickenpox       |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Spasms/Cramping    | <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Plantar Warts    |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Numbness/Tingling  | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Athlete's Foot   |
| <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart Condition         | <input type="checkbox"/> Open Cuts/Wounds |
| <input type="checkbox"/> Sciatica             | <input type="checkbox"/> Whiplash           | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Pregnant         |

### YOUR SIGNATURE BELOW INDICATES YOUR COMPLIANCE WITH THE FOLLOWING POLICIES:

**CANCELLATIONS OR NO SHOW:** If you need to cancel your session, 24 hours notice is required. If proper notice is not given, you will be charged a \$30 cancellation fee. If I need to cancel within 24 hours of the session, you will receive a complimentary session for your next appointment. **SESSION TIME:** Sessions begin and end at scheduled times. Sessions begun late due to client arriving late end at appointed time and are full price. If I arrive late, I will apply the missed time to your next session. Session time may include pre-treatment interview, as well as post treatment follow-up with self-care suggestions. **SCOPE OF PRACTICE:** Massage Therapy is a hands-on approach to restoring and enhancing health by removing imbalances and tension in muscles and other soft tissues connecting your entire body. I do not diagnose or treat medical conditions. I work closely with any referring doctor and integrate his or her information into my evaluations. I happily refer clients to other qualified professionals if they have a need for additional health services. **CONFIDENTIALITY:** All health information or personal conversation during a massage is strictly confidential. This information will only be released with the client's written consent or if legally subpoenaed.

Signed \_\_\_\_\_ Date \_\_\_\_\_