CONFIDENTIAL HEALTH HISTORY

Welcome! We want to make your time with us as pleasant and comfortable as possible.

If you have any questions or concerns regarding your appointment,
please let us know as soon as possible. We look forward to working with you!

—— PLEASE PRINT OR WRITE CLEARLY THANK YOU! ——

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____ TODAY'S DATE _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____ ☐ Yes, please send me periodic e-mail updates and specials. (I may un-subscribe at any time.)

Please mark (☑) your preferred contact number for appointment reminders, etc.

☐ HOME PHONE _____ ☐ CELL PHONE _____ ☐ WORK PHONE _____

DATE OF BIRTH _____ AGE* _____ ☐ Male ☐ Female MARITAL STATUS: _____

*Signed parental consent required if under 18

OCCUPATION _____ EMPLOYER _____

HOW DID YOU HEAR ABOUT US? ☐ Gift Certificate ☐ Social Media (Specify): _____

☐ Medical referral from: _____ ☐ Other (specify): _____

ARE YOU PREGNANT? ☐ NO ☐ YES / Due Date: _____

Name of Prenatal Caregiver / Physician: _____

CURRENT MEDICATIONS OR SUPPLEMENTS? ☐ NO ☐ YES (please list below):

_____

_____

DO YOU HAVE ANY ALLERGIES? ☐ NO ☐ YES (please list below):

_____

EMERGENCY CONTACT: _____

Name / Relationship Telephone

Continued on other side >>>

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?:

☐ Accident	☐ Broken bones	☐ Colitis / IBS
☐ Anxiety or Depression	☐ Joint ache	☐ Asthma
☐ Arthritis, bursitis or gout	☐ Sciatica	☐ Tuberculosis
☐ Neck pain	☐ Sprains	☐ HIV / AIDS
☐ Whiplash	☐ Seizures	☐ Hepatitis
☐ Headaches	☐ Abdominal pain	☐ MRSA
☐ High blood pressure	☐ Nervous tension	☐ Staph Infection
☐ Shoulder pain	☐ Scoliosis	☐ Athletes Foot
☐ Upper back pain	☐ Osteoporosis	☐ Varicose veins
☐ Mid back pain	☐ Fibromyalgia	☐ Phlebitis
☐ Low back pain	☐ Diabetes	☐ Blood clots
☐ Decreased range motion	☐ Lyme Disease	☐ Stroke
☐ Carpal tunnel syndrome	☐ Spinal Stenosis	☐ Heart attack
☐ Mastectomy	☐ Kidney Disease	☐ Lupus
☐ Breast Augmentation	☐ Cancer:_____	☐ Surgery _____

☐ OTHER / NOTES: _____

_____

ARE YOU BEING TREATED FOR ANY OF THE ABOVE CONDITIONS?

☐ NO ☐ YES (Describe): _____

DO ANY OF THE FOLLOWING APPLY TO YOU TODAY?

☐ Wearing contact lenses	☐ Inflammation	☐ Cold, flu, fever
☐ Open cuts, bruises, burns	☐ Sunburn	☐ Headache/Migraine
☐ Irritated skin / rash	☐ Severe pain	☐ Incontinence (*Bladder/Bowel)*

☐ OTHER (prosthesis, blood clot, etc.): _____

_____

☐ Pain medication. If yes, what? _____

_____

WILL THIS BE YOUR FIRST MASSAGE? ☐ YES ☐ NO
If NO, how long since your last massage? _____

WHAT ARE YOUR GOALS/EXPECTATIONS FOR TODAY'S SESSION?

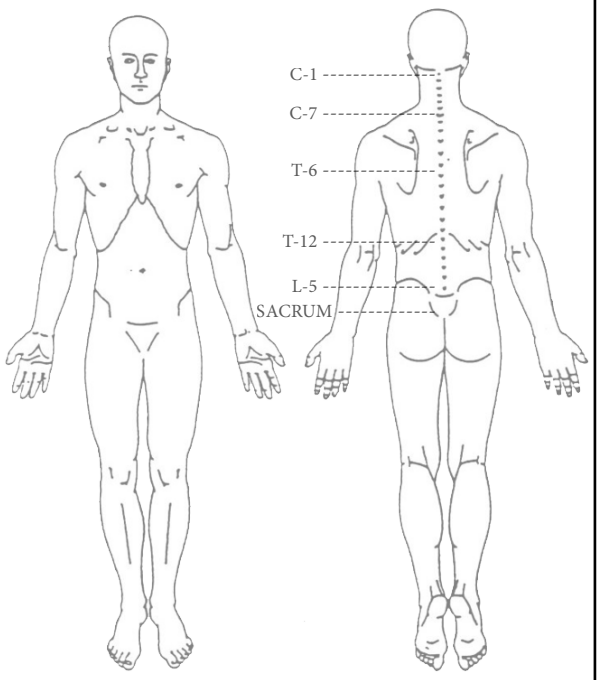
_____

_____

Please Indicate Your Consumption Level:

	None	Light	Moderate	Heavy
Salt:	☐	☐	☐	☐
Sugar:	☐	☐	☐	☐
Caffeine:	☐	☐	☐	☐
Tobacco:	☐	☐	☐	☐
Alcohol:	☐	☐	☐	☐
Exercise:	☐	☐	☐	☐
Water:	☐	☐	☐	☐

PLEASE INDICATE WITH AN (X) THE AREAS YOU ARE FEELING DISCOMFORT:



PLEASE READ THE FOLLOWING AND SIGN BELOW:

I confirm that the above information is true to the best of my knowledge and understand that massage therapy is not a substitute for medical care and that no diagnosis will be made. • I hereby give consent for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me and for general administrative operations of the practice. • I understand that payment is due when services are rendered and that I am responsible for paying for any missed appointment(s) or any appointment(s) not cancelled as explained in our **APPOINTMENT POLICY.** ➔➔

_____ _____

SIGNATURE ***DATE***

APPOINTMENT POLICY

We require 24-HOURS NOTICE to cancel or reschedule an appointment. • Failure to honor this policy will result in a CANCELLATION FEE OF 50% of the value of your service. • Neglecting to call us to cancel an appointment will result in a NO SHOW FEE OF 100% of the value of your service. • Exceptions will be made for emergencies and inclement weather. • We reserve the right to require Credit Card or Gift Certificate info to hold appointments. • *Thanks for your cooperation!*

*PARENT / GUARDIAN Signature (if applicable) Printed Name & Relationship Date