PERSONAL HEALTH INFORMATION

Title | First Name | MI | Last Name | Date

Address | Occupation

City | St | Zip | Home Phone/Notes

Email | Cell Phone/Notes

Referred by person | Referred by other | DOB | Work Phone/Notes

Primary Health Care Physician | Emergency Contact | Relationship

Primary Physician Phone/Notes | Emergency Contact Phone/Notes

Permission to consult with primary care physician? Please initial if yes. Yes ☐ Initial ☐ No ☐

Other Physicians/Therapists/Complementary Health Care Providers/Phone/Notes:	Permission to consult? Yes	Initial	No

Medical History:

☐ Abdominal Pain	☐ Decrease Range of Motion	☐ HIV	☐ Nervous Tension	☐ Surgery
☐ Accident	☐ Diabetes	☐ Joint Ache	☐ Osteoporosis	☐ Upper Back Pain
☐ Arthritis	☐ Disk Problem	☐ Low Back Pain	☐ Sprains	☐ Varicose Veins
☐ Broken Bones	☐ Heart Attack	☐ Mid Back Pain	☐ Stiffness	☐ Whiplash Seizures
☐ Cancer	☐ High Blood Pressure	☐ Neck Pain	☐ Stroke	

Other:

☐ Allergies	☐ Caffeine/Nicotine	☐	☐	☐
☐ Drugs/Alcohol	☐ Pregnant	☐	☐	☐

Other/Details:

History/Notes:

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Are you currently seeing a medical practitioner? Please explain if yes. ☐ Yes ☐ No _____

_____

Are you currently seeing a psychotherapist or are you attending group support meetings? Please explain if yes. ☐ Yes ☐ No

_____

Medications/Purpose/Dosage:

Supplements/Purpose/Dosage:

Exercise/Stress Reduction Activities:

☐ Aerobics ☐ Sports ☐ Swimming

☐ Running ☐ Biking ☐

☐ Walking ☐ Gym ☐

Details of Exercise/Stress Reduction Activities/Notes:

Other Physical Activities/Details/Notes:

Massage/Bodywork History/Treatment Information:

Have you ever received a professional massage? ☐Yes ☐ No If yes, Frequency _____Date of last massage_____

What type of massage/bodywork have you received?_____

What type of massage/bodywork do you prefer?_____

What results are you seeking from treatment?_____

Prioritize the areas of your body that need treatment._____

Please check areas of your body that you give permission to receive massage. ☐ Head ☐ Face ☐ Neck ☐ Shoulders

☐ Arms ☐ Hands ☐ Upper Chest ☐ Abdomen ☐ Back ☐ Hips ☐ Buttocks ☐ Legs ☐ Feet

Treatment Details/Notes:

PERSONAL HEALTH INFORMATION

Client Agreement of Responsibility:

I have stated all medical/mental conditions, treatments and medications that I am aware of and I will update the massage therapist of any changes in my health status, treatments and medications. Initial ☐

I understand that it is my choice to receive massage/neuromuscular/acupressure therapy. I understand that treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain and/or for increasing circulation or energy flow. I agree to immediately communicate to the massage therapist any time I feel that my well being is being compromised. Initial ☐

I understand that massage therapists do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage/bodywork therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. Initial ☐

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I also understand that I am responsible for payment if third party payment is not made. Initial ☐

I agree to give 24 hours notice to cancel or reschedule my appointment. I understand that missed appointments or those cancelled with less than 24 hours notice are subject to a $75 late cancellation fee. Initial ☐

I understand that third parties cannot be billed for missed appointments and that payment is my responsibility.

I understand that it is my responsibility to be on time for my appointment and ready to receive therapy at the appointed time; that any time that I am late will be deducted from my session and that I am responsible to pay for the full session. Initial ☐

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this record will be placed in my client chart and maintained for six years. Initial ☐

Client Name (Please Print) _____Date_____

Parent, Guardian or Client's legal representarive_____

Signature_____