Massage Client Health Information Form

31395 W. Seven Mile Rd., Suite G
Livonia, MI 48152

Date: _____

Confidential Client Information

Name: _____ Preferred Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____ Email: _____
Date of Birth: _____ Occupation _____
Emergency Contact Name: _____ Phone: _____
Relationship: _____
Whom may we thank for referring you? _____

Health History

Please indicate any conditions; the more detailed your past history the more helpful I can be for your present. Where possible, label the year of condition diagnosis:

☐Anemia
☐Asthma
Do you carry an inhaler? Where is it located in case of emergency?
_____
_____
☐Anorexia/ Bulimia
☐Arthritis
☐Allergies/ type?
_____
_____
☐Anxiety
☐Blood Clotting Disorder

☐ Blood Pressure High/Low
☐ Bone Spur
☐Breathing Difficulty
☐ Broken Bones mm/dd/yy and bone:
_____
_____
☐ Bruise Easily
☐Cancer; Type, Remission Date:
_____
_____
☐Chemical Dependency
☐Dizziness

☐Diabetes:
Do you have a pump? Do you have sugar pills on you? If so, where are they located?
_____
_____
_____
☐Epilepsy /Seizures
☐Edema/swelling/ inflammation Location/severity/ date noticed:
_____
_____

☐Fibromyalgia
☐Glaucoma
☐Headaches
☐Head Injuries
☐Hearing Difficulties
☐Heart Disease
☐Heart Burn
☐Hepatitis
☐Hernia
☐Herpes
☐Hiatal Hernia
☐HIV/AIDS

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☐Jaw Pain/TMJ
☐Joint replacement
☐Lymph edema
☐Neck/Back Pain
☐Neuropathy
☐Organ transplant
☐Osteoporosis
☐Pacemaker
☐Pinched nerve
☐Prosthesis
☐Pregnancy
☐Rotator Cuff Injury
☐Sleep Apnea
☐Sprains/Strains/ muscular injuries mm/dd/yy and area of body:
_____
_____
_____
_____
☐Stress
☐Varicose veins

Medications:

NAME	DOSAGE	FREQUENCY	CONDITION

Surgeries:

TYPE:	DATE:

Exercise: ☐None ☐Type of Exercise & Frequency_____

_____

Work Activity: ☐Standing ☐Sitting ☐Light Labor ☐Heavy Labor ☐Other_____

Lifestyle: ☐Smoking:____packs/day ☐Coffee/caffeine:_____cups/day ☐Alcohol:_____drinks/week/mo/yr ☐Water_____oz/day

Massage History

Have you ever received a professional massage? ☐Yes ☐No

Date of last massage (if not exact, about how many months or years):_____

What condition was your last massage for?_____

What were the results of your last massage?_____

How long did your results last?_____

Did the therapist give you any stretches/exercise/homework, if so what kind and are you currently doing them?_____

_____

What results would you like to receive with our services? _____

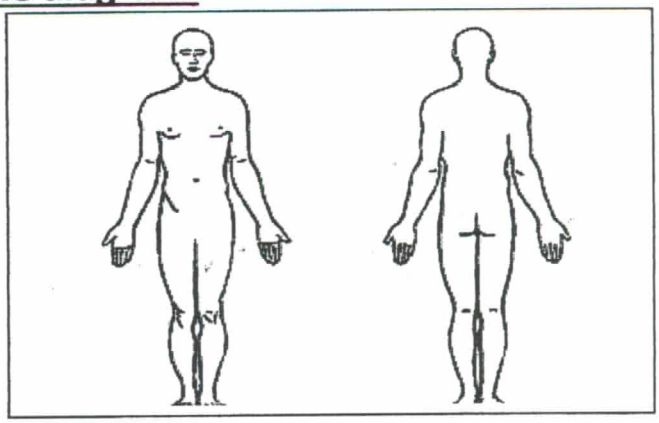
_____

Please note any areas of your body that you prefer not to be massaged:

_____

History of Current Condition

Please circle your area(s) of discomfort on the diagram:



When did your symptoms first appear? _____

Is your condition due to an accident? ☐Yes ☐No

Type of accident: ☐Auto ☐Work ☐Home

☐Other: _____

Type of symptom: ☐Tension ☐Pain ☐ Sharp ☐Aching

☐Throbbing ☐Dull ☐Shooting ☐Burning ☐Tingling

☐ Light ☐Moderate ☐Severe ☐Other_____

How often do you have these symptoms?_____

Does it interfere with: ☐Work ☐Sleep ☐Daily Routine

☐Recreational activities ☐Other_____

What are your main concerns that you would like to address during today's massage?

_____

What treatments (if any) are you currently using for your condition?

_____

Cancellation Policy

We are making a commitment to you to guarantee your appointment time and are refusing all other requests once you have made the appointment. A 24-hour cancellation notice is required for all scheduled appointments, including gift certificate sessions. Missed or no-show appointments will result in you being charged the full amount of the session booked unless the appointment can be filled. Insurance does not cover cancellations. Emergency cancellations will be taken into consideration by the massage therapist. Clients who have more than two missed appointments or same-day cancellations will be asked to guarantee all future appointments with a credit card.

Depending on our booking schedule, late arrival appointments may not receive the full session time allotted for the treatment service booked; full payment is required. Insurance does not cover time loss._____

Acknowledgement of Protected Health Information Practices: It is understood that by Federal Law, my personal health information is protected. This office has available for review its' Health Privacy Policy. Should I have any question regarding this policy, I will contact this office._____

I understand that the massage/bodywork I receive is for the purpose of relaxation, relief of muscular tension and spasm, and the increasing of circulation and energy flow. If I experience any pain or discomfort during the sessions, I will inform the practitioner so that the pressure and/or techniques may be adjusted to my level of comfort. I understand that massage/bodywork is not a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment. I understand that massage/bodywork practitioners do not diagnose, prescribe, or treat any physical or mental illness. I affirm that I have stated all my known medical conditions. I agree to keep the practitioner updated as to any changes to my medical profile.

Signature_____ **Date**_____