



HEALTH STUDIO CLIENT INFORMATION AND HEALTH HISTORY



WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions about your session or treatment plan, please let me know.

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ OCCUPATION: _____ MARITAL STATUS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP _____ PHONE: _____

EMAIL ADDRESS: _____ REFERRED BY: _____

Have you ever had a Professional Massage Before? _____ If Yes, how frequently _____

What do you hope to accomplish from todays massage? _____

Are you aware of any tension holding spots in your body? _____ If Yes, location(s) _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

What type of care did you receive for your accidents or injuries? _____

Do you feel you have recovered from these events? _____ Please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____ Please explain: _____

Describe what activities cause this pain and/or make it worse: _____

Are you receiving any other type of medical treatment? _____ Please explain: _____

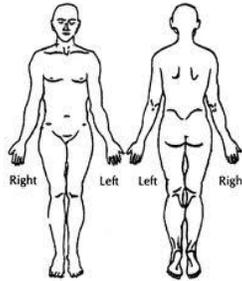
Please list any medications (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what each medication is used to treat): _____

Are you currently under the care of a physician? _____ Whom? _____

Please list reason(s): _____

Are there any health concerns you wish to discuss today _____ If yes, please describe: _____

Please indicate with an (X) any areas that you are feeling pain or discomfort:



Are you currently experiencing any of the following conditions?

Flu or cold _____ Inflammation _____ Fever _____ Infection _____ Rash _____ Cuts _____ Contagious Disease _____

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years:

<p>MUSCULOSKELETAL</p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Spasms/Cramps</p> <p><input type="checkbox"/> Sprains/Strains</p> <p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Postural Deviations</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Osteoarthritis/Rheumatoid Arthritis</p> <p><input type="checkbox"/> TMJ</p> <p><input type="checkbox"/> Cysts</p> <p><input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> Plantar Fasciitis</p> <p><input type="checkbox"/> Tendonitis</p> <p><input type="checkbox"/> Torticollis</p> <p><input type="checkbox"/> Whiplash Syndrome</p> <p><input type="checkbox"/> Carpal Tunnel Syndrome</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Leg Pain</p> <p><input type="checkbox"/> Arm Pain/Shoulder Pain</p> <p><input type="checkbox"/> Mid Back Pain</p> <p><input type="checkbox"/> Low Back Pain</p> <p><input type="checkbox"/> Hip Pain <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Other _____</p>	<p>CIRCULATORY</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> Raynaud's Disease</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Heart Condition</p> <p><input type="checkbox"/> Blood Clots/Phlebitis</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Other _____</p> <p>DIGESTIVE</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Irritable Bowel Syndrome</p> <p><input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> Gallstones</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Crohn's Disease</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Gas/Bloating</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Other _____</p>	<p>NERVOUS SYSTEM</p> <p><input type="checkbox"/> ALS</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Parkinson's Disease</p> <p><input type="checkbox"/> Bell's Palsy</p> <p><input type="checkbox"/> Neuritis</p> <p><input type="checkbox"/> Spinal Cord Disease</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Trigeminal Neuralgia</p> <p><input type="checkbox"/> Seizure Disorders</p> <p><input type="checkbox"/> Numbness/Tingling/Twitching</p> <p><input type="checkbox"/> Other _____</p> <p>OTHER</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Anxiety/Panic Attacks</p> <p><input type="checkbox"/> PMS</p> <p><input type="checkbox"/> Grief Process</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Chronic Fatigue</p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Lupus</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Kidney Stone(s)</p> <p><input type="checkbox"/> Bladder Infection</p> <p><input type="checkbox"/> Postoperative Situation</p> <p><input type="checkbox"/> Edema</p> <p><input type="checkbox"/> Other _____</p>
<p>RESPIRATORY</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Trouble Breathing</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Other _____</p>	<p>SKIN</p> <p><input type="checkbox"/> Fungal Infections</p> <p><input type="checkbox"/> Acne</p> <p><input type="checkbox"/> Impetigo</p> <p><input type="checkbox"/> Dermatitis/Eczema</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Open Wound or Sore</p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Warts/Moles</p> <p><input type="checkbox"/> Athletes Foot</p> <p><input type="checkbox"/> Other _____</p>	

The above information is accurate and true to the best of my knowledge. I understand that Massage Therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical examination, diagnosis and treatment. I take responsibility for advising my therapists of any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hour notice (medical emergencies excluded) may be charged in full for the price of the missed session. I understand that my Personal Health Information will be handled by the policies described in the Health Studio Notice of Privacy Practices. By signing I agree to these policies.

SIGNATURE _____ DATE: _____