

## CONFIDENTIAL HEALTH HISTORY FORM

Please complete this short form in order to provide you with the best possible therapy according to your individual needs. Thank you. Today's date: \_\_\_\_\_

**NAME:** (last name) \_\_\_\_\_ (first) \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:**(home, cell, emergency #'s) \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

**OK to contact:** phone? Yes \_\_\_No\_\_\_; mail? Yes \_\_\_No\_\_\_; e-mail? Yes \_\_\_No\_\_\_

**Referred by:** Website: \_\_\_ Internet listing: \_\_\_ Other \_\_\_\_\_

Have you had therapeutic massage before? \_\_\_ If yes, (circle one) prefer light, moderate or deep pressure. Have you ever been told you should NOT have massage therapy (if so, indicate reason)? \_\_\_\_\_

Please circle any areas of tension or

**pain:**

Have you ever had any of the following:

\_\_\_ **Plef**  
\_\_\_ **Osteoporosis**

\_\_\_ **Headaches**

\_\_\_ **Phlebitis**

\_\_\_ **Arthritis**

\_\_\_ **Diabetes**

\_\_\_ **Pregnancy**

\_\_\_ **Varicose veins**

\_\_\_ **Burns**

\_\_\_ **Skin Rashes**

\_\_\_ **Cancer**

\_\_\_ **Severe Pain (Where?)** \_\_\_\_\_

\_\_\_ **High Blood Pressure**

\_\_\_ **Broken Bones (When?)** \_\_\_\_\_

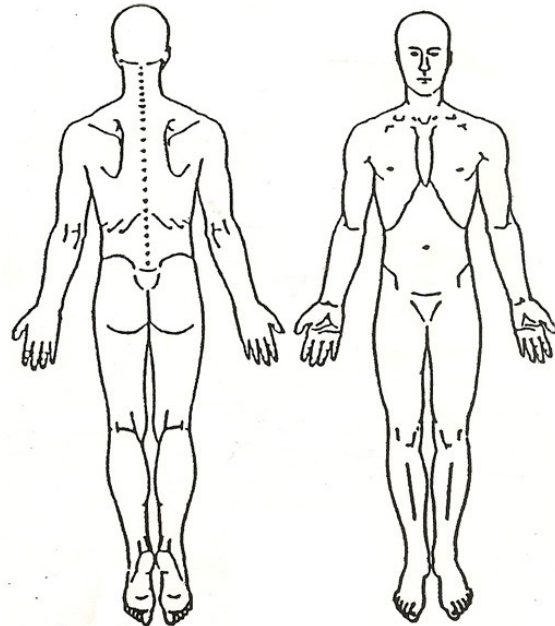
\_\_\_ **Whiplash (When?)** \_\_\_\_\_

\_\_\_ **Sprain/Strain (When?)** \_\_\_\_\_

\_\_\_ **Surgery(Explain:** \_\_\_\_\_

**Other Medical conditions:** \_\_\_\_\_

**Medications:** \_\_\_\_\_



**Please read the following and sign:**

Cancellation Policy: The full fee will be charged for any missed appointments without a full 24-hour cancellation notice (except, of course, in extreme emergency), given **by phone only**. (E-mail notice will not suffice.) Also, promptness is appreciated. Out of respect for the clients scheduled after your treatment time, if you are late, you will only be offered that part of your appointment time that is still available to you. You will be charged the full fee for the reserved time. Thank you for your understanding.

The practitioner whose name appears below is not responsible for the aggravation of conditions which were present, but not disclosed, at the time of the massage and which may be affected by the massage.

Client signature: \_\_\_\_\_

Practitioner signature: \_\_\_\_\_