Crazi Springz Classical Pilates and Body Work
Health History Form

Body Work Health History Form

(Please Print Clearly)
Name:____Date: (M)____(D)_____(Y)________

Address:______________________________________City:_________________________

Postal Code:_______________________ Phone Number (H)_____________
(Cell)_________________________

Date of Birth: (M)________(D)_________(Y)________

Gender: M or F ____________________ Email Address:__________________

Who may we thank for the referral?____

Tell us a little about yourself:

Occupation:_______________________How many hours do you work daily?______hrs

How many hours of sleep (average) do you get? ___________________

Have you had a professional massage before? Y or N
If yes, when was your last treatment?(M)______(D)________(Y)_________
Have you had Myofascial Cupping in the past? Y or N
Have you had Cranio Sacral Therapy in the past? Y or N
Have you had Deep Tissue Massage in the past? Y or N
Do you bruise easily? Y or N
Are you a diabetic? Y or N
Do you have any allergies to massage lotions or oils? Y or N if yes which one________
Do you have sensitive skin? Y or N
Do you wear contact lenses? Y or N
Do you sit for hours at a workstation, computer or driving? Y or N
If yes, please describe____
Do you perform any repetitive movement in your work, sports or hobby? Y or N
If yes, please describe____
Do you experience stress in your work, family, or other aspects of your life? Y or N
If you, how do you think this has affected your health?
Muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____________
Is there a particular are of the body where you are experiencing tension, stiffness, pain or other discomfort? Y or N
If yes, please identify____
Do you have any particular goals in mind for this massage session Y or N
If yes, please explain____

Medical History
In order to plan a massage session that is safe and effective, I need some general information about your medial history
Are you under medical supervision Y or N
If yes, please explain____
Do you see a Chiropractor? Y or N
If yes who is your Chiropractor____
How often do you go for adjustments____

Crazi Springz Classical Pilates and Body Work
Health History Form

Are you currently taking any medications Y or N
If yes, please list____
Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) joint disorder arthritis
( ) recent fracture
( ) artificial joints
( ) sprains/strains
( ) allergies/ sensitivity
( ) TMJ
( ) high or low blood pressure
( ) circulatory disorder
( ) tennis elbow
( ) pregnancy If yes, how many months?
( ) phlebitis
( ) deep vein thrombosis/ blood clots
( ) osteoporosis
( ) recent surgeries
( ) pins, needles plates to hold bone
( ) back / neck problems
( ) fibromyalgia
( ) heart condition
( ) Carpal tunnel syndrome
( ) varicose veins
( ) atherosclerosis

Please explain any conditions that you have marked
____
____
____

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?____

Written Inform Consent (please print clearly)

I ____________________________understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session and future sessions, I will immediately inform the practitioner so that the pressure or myofascial cups may be adjusted to my level of comfort. I understand with the use of the myofascial cups I may have bruising which may appear immediately or within 24 hours after treatment and this is a normal due to the toxin being released from the tissue. I further understand that massage should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.
I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's (Silvia Desmond-Hoare NHPC) part should I fail to do so.

Signature of Client________________________________ Date (m)_____ (D) _____ (Y)_______

Signature of Massage Practitioner ___________________ Date (m)____ (D) _____ (Y)_______

447 Pentiction Ave, Penticton BC V2A-2M5 (250)-460-3094
www.crazispringz.com
email crazispringz@gmail.com
Owner/Pilates Teacher/Myofascial and Cranio Sacral Therapist Silvia Desmond NHPC