Massage Treatment Health History Form (Please Print Clearly)

Name:_____ **Today's 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 medical 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_____
Are you currently taking any medications Y or N
If yes, please list_____

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Silvia Desmond NHPC PMAOwner/PMA Certified Pilates Teacher/Certified Health Care Practitioner

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?

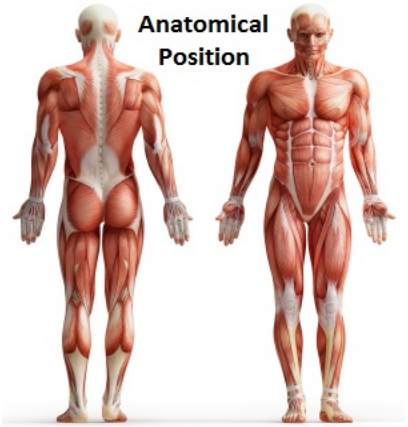
( ) phlebitis
( ) deep vein thrombosis/ blood clots
( ) osteoporosis
( ) recent surgeries
( ) pins, needles plates to hold bone
( ) back / neck problems
( ) fibromyalgia
( ) heart condition
( ) Carpal tunnel syndrome
( ) varicose veins
( ) atherosclerosis

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?_____
Please indicate any areas of the body front or back that is feeling not so right …

Mark on chart ----------→

Tightness XXX
Numbing////
Pain 0
Referral pain >>>>



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 my 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 practitioner 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)_____

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