

*** HANDS ON HEALING * CONFIDENTIAL HEALTH HISTORY ***

Name: _____ Date: _____ Referred by: _____

Home address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Gender: Male / Female

Home #: _____ Work #: _____ Cell #: _____ D.O.B.: _____

Occupation: _____ Employer: _____

Emergency contact: _____ Phone #: _____

Have you ever received a professional massage? Yes / No What results do you expect from your massage? _____

Please indicate the areas of your body that you give us permission to massage:

Arms { } Back { } Buttocks { } Chest { } Face { } Feet { } Hands { } Head { } Legs { } Neck { }

Are you currently seeing a medical doctor? Yes / No If yes, please explain. _____

List current medications, including over-the-counter meds, vitamins, etc.: _____

List any known allergies: _____

Please indicate the appropriate level for each of the following:

	<u>None</u>	<u>Light</u>	<u>Moderate</u>	<u>Heavy</u>
Alcohol	{ }	{ }	{ }	{ }
Caffeine	{ }	{ }	{ }	{ }
Exercise	{ }	{ }	{ }	{ }
Tobacco	{ }	{ }	{ }	{ }
Water	{ }	{ }	{ }	{ }

Please indicate any of the following issues that pertain to you:

<u>Muscular-Skeletal</u>		<u>Circulatory</u>		<u>Reproductive</u>	
Arthritis	{ }	Blood clots	{ }	PMS	{ }
Bone or joint disease	{ }	Breathing difficulty	{ }	Pregnancy	{ }
Broken / fractured bones	{ }	Heart condition	{ }	Other	{ }
Bursitis	{ }	High blood pressure	{ }		
Carpal tunnel	{ }	Lymph edema	{ }	<u>Skin</u>	
Fibromyalgia	{ }	Sinus problems	{ }	Athlete's foot	{ }
Headaches / head injuries	{ }	Varicose veins	{ }	Rashes	{ }
Pain – Arm, neck, shoulder	{ }	Other	{ }	Warts	{ }
Pain – Back, hip, leg	{ }			Other	{ }
Pain – Jaw / TMJ	{ }	<u>Other</u>			
Spasms / cramps	{ }	Cancer / tumors	{ }	<u>Nervous System</u>	
Sprains / strains	{ }	Depression	{ }	Chronic pain	{ }
Tendonitis	{ }	Diabetes	{ }	Fatigue	{ }
Other	{ }	Eating disorders	{ }	Herpes / shingles	{ }
		Lupus	{ }	Numbness / tingling	{ }
<u>Infectious Diseases</u>				Sleep disorders	{ }
Name of disease(s):	{ }			Other	{ }

BY SIGNING BELOW I ACKNOWLEDGE UNDERSTANDING OF AND AGREEMENT TO THE FOLLOWING:

- **CANCELLATION POLICY:** Should I be unable to make it to a scheduled appointment, it is my responsibility to call and cancel this appointment. I will provide at least 24 hours notice. Missing appointments or cancelling appointments at the last minute will result in a fee of half the price of the scheduled massage.
- The massage therapists at Hands on Healing must be aware of any existing physical conditions I may have; therefore, I have listed all of these issues and I agree to inform my therapist(s) of any change(s) in my health. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a medical doctor for these services. I agree to communicate with my therapist any time I feel that my wellbeing is compromised.
- I UNDERSTAND THAT MY SESSION(S) ARE STRICTLY ETHICAL AND THERAPEUTIC. IMPROPER BEHAVIOR WILL NOT BE PERMITTED. SHOULD IMPROPER BEHAVIOR OCCUR, MY SESSION(S) WILL BE DISCONTINUED IMMEDIATELY AND PAYMENT IN FULL WILL BE RENDERED.

Signature: _____ Date: _____