Confidential Massage Therapy Patient History

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Occupation:_____ Work Responsibilities:_____

Primary Care Physician:_____ Phone: _____

Emergency Contact:_____ Relationship:_____ Phone:_____

Email Address:_____

Circle ANY of the following that apply to your health:
Are You Currently Under A Doctors Care? _____ If Yes Explain:_____

allergies / sensitivities anything contagious heart conditions TMJ	arthritis diabetes HIV High/Low blood pressure varicose veins	blood clots difficulty breathing kidney problems Hepatitis fever	cancer epilepsy /seizures mental health illness gout	circulatory conditions headaches / migraines skin / fungal condition poison ivy/rash

Pregnant? Which trimester?__1st __2nd __3rd

Have you received massage therapy before:_____ If yes, How Often?_____

Today's primary concern or goal:_____ Other concerns/goals:_____

Classify Concern: __Minor __Problematic __Major

Classify Type: __Recurring/Chronic __Getting worse __Getting better

Have you had treatment for this before:_____

List activities affected:_____

Exercise activities:_____

Previous History: Please list in chronological order, stating dates or ages and treatment received:

Surgeries:_____

Accidents:_____

Major illnesses:_____

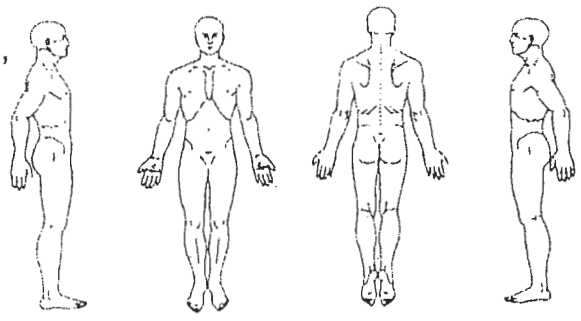
Current Medications (including over the counter):_____

Any thing else the Massage Therapist should know: _____

_____

How did you hear about us? _____OR Who may we thank for referring you?_____

Mark on figures all areas of pain, tenderness, numbness, stiffness and swelling:



Consent for Treatment: {Signature)_____ **Today's Date:**_____

Health Screening Survey

Please circle any of the following symptoms you have experienced in the last **6 months**

Headaches/ migraines
Fatigue
Irritability
Sinus Problems
Asthma
Insomnia/Sleep Problems
Ringing in Ears
Dizziness
Nervousness
Menstrual Problems
Bladder Problems
Digestive issues:
Constipation
Diarrhea
Gas
Bloating

Pain in the following areas:
Neck Shoulders Low back Legs Arms Hands Feet

Tension in the following areas:
Neck Shoulders Low back Legs Arms Hands Feet

Numbness in the following areas:
Neck Shoulders Low back Legs Arms Hands Feet

Tingling in the following areas:
Neck Shoulders Low back Legs Arms Hands Feet

Other:

_____
_____
_____
_____

If any, which of the marked about bothers you the most?

_____

Please describe how it feels or affects you when these symptoms are at their worst?

_____
_____
_____

Does this cause you to be: Moody Irritable

Or Interrupt your sleep Restrict daily activities

Does this affect your work? Decision making Poor attitude
Exhausted at night fall Decreased Productivity Unable to work Long hours

Does this affect your life? Lose patience easily Restricts household duties
Hinders ability to exercise/sports
Interferes with to participate in hobbies/activities you enjoy

How long have these symptoms been bothering you?

_____

Holten Wellness Center
Policies

Payment:
Payment is expected at the time of scheduling the appointment in order to reserve your appointment. Payment will be accepted by cash, charge or check made out to Holten Wellness Center.
** There will be a $25.00 fee applied to any returned checks.

Late Policy:
If client is late for a scheduled session, the session will still end at the planned time. If the therapist/technician is late, every effort will be made to ensure fairness by allotting more time or decreasing the fee.

Cancellation Policy:
Please give at least 6 hours notice for cancellations. Patients *not giving* at least 6 hours notice will be charged $35.00 for any *missed* scheduled appointment.

Massage Ethics:
Massage is a medical procedure. Any misconduct (sexual or otherwise) is not acceptable and will not be tolerated. This will result in the immediate termination of the massage session and any scheduling of future appointments.

Consent For Massage/Esthetics Care:
I have completed these forms to the best of my knowledge. I understand that massage therapy is designed to be a health aid and is in no way to take the place of medical care when it is indicated. I, to the best of my knowledge, have no physical conditions that would be contraindicated for massage therapy or esthetics services and will inform my therapist/Esthetician of any changes in my health status. By signing, I hereby release, waive, discharge and hold harmless from any and all liability, claims, costs and expenses whatsoever arising out of or related to any loss, damage, or injury, that may be sustained while receiving any treatment at Holten Wellness Center. In addition, I agree to abide by the rules and recommendations associated with any treatment received at Holten Wellness Center, as explained by the therapists or technicians.

_____

Signature Date