

CLIENT HEALTH HISTORY FOR MASSAGE

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Please note: Any information exchange on this form or during a massage therapy session is considered confidential and used only to provide you with the best health care services possible.

Name: _____ Birthday (month/date/year): _____
Address: _____ City: _____ Zip: _____
Home Phone : () _____ Office Phone: () _____ Mobile Phone: () _____
Occupation: _____ Referred by: _____
Email Address: _____

In case of emergency, contact information:

Name: _____ Phone number: () _____
Address: _____ State: _____ Zip: _____

General & Health- Related Information: Please circle either yes or no to the following questions:

Are you currently under a physician's care? (YES or NO)

If "yes" please describe: _____

Have you received massage therapy before? (YES or NO)

If "yes" what kind(s)? _____ How often? _____

Do you wear contacts lenses or dentures? (YES or NO)

Do you frequently suffer from stress? (YES or NO)

Do you experience frequent headaches? (YES or NO)

Do you participate in any sports or exercise? (YES or NO) If "yes" how often? _____

Are you taking any medications? (YES or NO): If "yes" what kind: _____

Are you epileptic? (YES or No)

Do you have cardiac or respiratory problems? (YES or NO)

Are you very sensitive to touch/pressure in any particular body area? (YES or NO) If "yes" Where? _____

Please check off any of the following conditions or symptoms which apply to you now or in the past:

High blood pressure Low blood pressure Skin infections Bruises
 Low back pain Diabetes Numbness/tingling Muscle Sprain/Strain
 Allergies Varicose veins Skin problems Osteoporosis
 Blood clots Bursitis Arthritis

Please describe any other condition(s) not listed above: _____

Have you had any new or old injuries, or have you had any surgeries? (YES or NO) if "yes" please list date(s): _____

Are you currently under the care of a chiropractor? (YES or NO)

Are you having any discomfort? (YES or NO) on a level of 1-10(1=minor 10=extreme) please rate your discomfort: _____

Are you allergic to any lotions, oils, scents or detergents? _____

Where area would you like me to focus on? Please list: _____

ONLY FOR FEMALES ONLY:

Are you pregnant? (Yes or No) *If “yes” Please fill out the information below*

Weeks pregnant: _____

Your Prenatal Care Provider’s (PCP) Name: _____

Office Phone () _____

When was your last prenatal care visit? _____

Are you taking any prescriptions/over the counter medications/ supplements/ herbs? _____

Have you been pregnant before? (YES or No) If “yes” Please answer the following:

How many times have you been pregnant? _____

Have you ever miscarried? (YES or NO)

Are you experiencing any of the following? (Check what applies to you)

Nausea Diarrhea varicose veins Dizziness Fetal movement reduction Fever

Insomnia Headaches Excessive Swelling vaginal bleeding or discharge

Poor circulation severe persistent pain that is not relieved by change in position

Do you have any complications or have a high-risk pregnancy? (Check what applies to you):

Preeclampsia/ Eclampsia Incompetent cervix Multiple gestation Uterine abnormalities

Placenta previa Placental abruption High blood pressure Gestational diabetes Blood clots/DVT

Anemia other: _____

General Questions:

Are you allergic to any lotions, oils, scents or detergents? _____

Have you used birth control pills within the last year? _____

Are you currently doing any prenatal exercise or yoga? _____

Have you had massage or prenatal massage before? _____

I understand that the massage/ bodywork I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomfort during the session(s), I will immediately and clearly inform the practitioner, so that the pressure and/or strokes may be adjusted to my communicated level of comfort.

I understand that massage/bodywork should not be construed or substitute for a medical examination, diagnosis, or treatment, and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I further understand that the practitioner is not a “provider of health care” for any purpose.

I understand that massage therapy/ body worker are not to perform spinal or skeletal adjustments, or diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) should be construed as such.

I understand that massage/ bodywork is contraindicated (should not be done), under certain medical conditions, I affirm that I have stated all I known medical conditions and answered honestly. I further understand as the client that I will be responsible for any new medical conditions that may occur, and I agree to keep the massage therapist/ bodyworker updated as to any changes in my medical profile as represented by me. And I understand that there shall be no liability on the massage therapist part should I fail, for whatever reason, to do so.

It is also understood that this is a therapeutic massage and is NON-SEXUAL; therefore no leet, or suggestive remarks or advances will be tolerated. This will result in immediate termination of the session(s), and I will be liable for payment for the “Full Schedule Appointment”.

I further understand, and acknowledge and certify that all the foregoing is true to the best of my knowledge and belief, and that I presently have no conditions that would make this release anything other than knowing and voluntary.

I also understand that anyone under the age of 18 years must have a parent or parental guardian sign for them, before proceeding with massage.

Name (Please print) _____ Date _____ Signature _____