# Massage Client Health History Form

**Name-** _____ **Primary Phone Number-** ( ) -

**Street Address-** _____ **Secondary Phone Number-** ( ) -

**City, State, Zip Code-** _____ **Work Phone Number-** ( ) -

**Date Of Birth-** _____ **Employer-** _____

**e-Mail-** _____ **Occupation-** _____

**Emergency Contact-** _____ **Emergency Phone Number-** ( ) -

**Please mark "X" for all of your current conditions and mark "P" for any of your past conditions.**
*****Some conditions may require precautions for your safety and wellbeing*****

| | | | |
|---|---|---|---|
| ☐ Allergies | ☐ Broken Bones | ☐ Cold/Flu | ☐ Jaw Pain (TMJ) |
| ☐ Anemia | ☐ Bruise Easily | ☐ Depression | ☐ Muscle Spasms |
| ☐ Anxiety | ☐ Cancer/Tumors | ☐ Diabetes | ☐ Neck/Back Injury |
| ☐ Arthritis | ☐ Cardiovascular Disease | ☐ Dizziness | ☐ Numbness/ Tingling |
| ☐ Asthma | ☐ Chest Pain | ☐ Epilepsy OR Seizures | ☐ Osteoporosis |
| ☐ Athelete's foot | ☐ Chronic Digestive Problems | ☐ Fibromyalgia | ☐ Pregnant |
| ☐ Atherosclerosis | ☐ Chronic Back Pain | ☐ Headaches/Migraines | ☐ -# of weeks |
| ☐ Blood Clots | ☐ Contagious Disease | ☐ Insomnia | ☐ Sprains/Strains |

**Please list and describe any other conditions you have or are experiencing**

**How did you hear about Therapeutic Arts & Massage Studio?** _____

**What type(s) of massage/bodywork have you received?** _____

**What are your goals with our massage session(s)?** _____

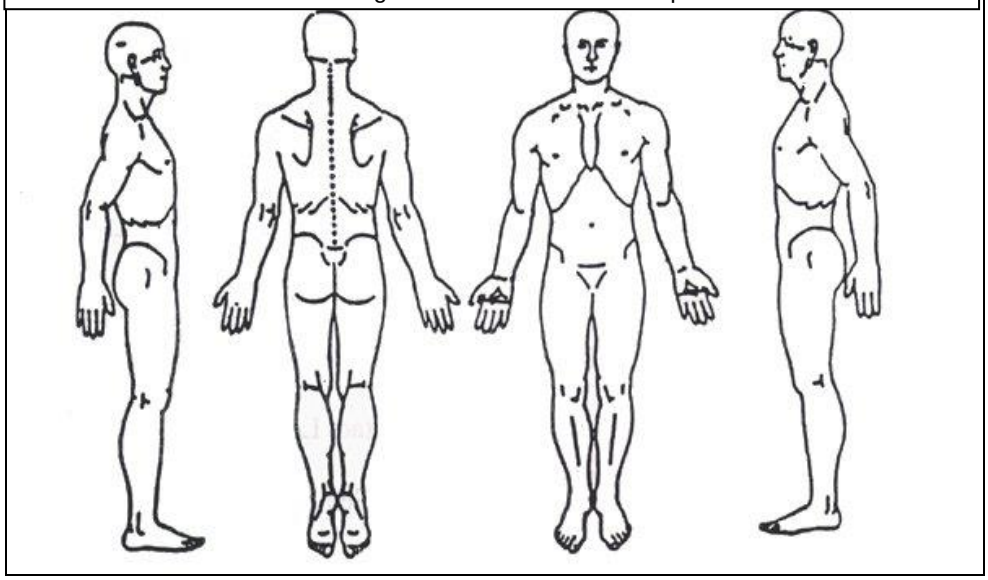
**Are you under the care of a medical doctor, chiropractor, or therapist?** _____

**Name:** _____

**List medications in the past 6 months:** _____

**Hobbies:** _____

Mark areas of tension on the diagram with a **"T"** & areas of pain/discomfort with a **"D"**



**I understand that massage and bodywork are not substitutes for medical treatment. I understand that massage and bodywork practitioners are not qualified to diagnose, treat, or prescribe for physical or mental illness. Therefore, no statement by the practitioner may be construed as diagnosis or prescription. Because massage and bodywork should be altered or avoided with certain medical conditions, I affirm that I have indicated all of my medical conditions and answered all questions honestly. I will inform the practitioner if there any changes to my health or medical condition. The practitioner shall not be liable for any false or omitted information from me, the client.**

**I will tell the practitioner immediately if I experience discomfort or pain during my session(s) so the practitioner can make adjustments to improve my comfort and well being during the session.**

**Draping will be used during each session in compliance with North Carolina law. I understand that any illicit or sexually suggestive remarks or advances by me, will immediately terminate the session and I will be liable to pay for the entire scheduled session.**

**I understand that I will be liable for full payment of any session cancelled less than 24 hours prior to my appointment.**

**Client Signature:** _____ **Date:** _____

**Practitioner Signature:** _____ **Date:** _____