# Medical | Health Information

1. Are you currently under a doctor's care? □ yes □ no
   If yes please explain: _____

   _____

2. List current medications, including aspirin, ibuprofen, vitamins, etc. _____

   _____

3. Do you have any allergies? □ yes □ no
   If yes please list: _____

   _____

4. Do you have any of the following? Check all that apply:

| | | |
|---|---|---|
| ☐ Abdominal Pain | ☐ Diabetes Type 1 | ☐ Nervous Tension |
| ☐ Accident | ☐ Diabetes Type 2 | ☐ Psoriasis |
| ☐ Arthritis | ☐ Depression | ☐ Rotator Cuff /Shoulder |
| ☐ Asthma | ☐ Fibromyalgia | ☐ Seizures |
| ☐ Athletes Foot | ☐ Gut | ☐ Scoliosis |
| ☐ Blood Pressure - Low | ☐ Headaches | ☐ Sciatica |
| ☐ Blood Pressure - High | ☐ Heart Problem | ☐ Sinus Trouble |
| ☐ Broken Bones | ☐ HIV | ☐ Sprains |
| ☐ Bursitis | ☐ Joint Aches | ☐ Stroke |
| ☐ Cancer | ☐ Lower Back | ☐ Trigger Finger |
| ☐ Carpal Tunnel | ☐ Mastectomy | ☐ Varicose Veins |
| ☐ Colitis | ☐ Mid-back Pain | ☐ Wear Contacts |
| ☐ Chronic Fatigue | ☐ Migraines | |

5. Please list any other past history: _____

   _____

6. Have you had any surgeries for major illnesses? □ yes □ no

   If yes please explain (include year and treatment): _____

   _____

   _____

7. Are you pregnant? □ yes □ no

8. Are you experiencing any of the following today?

| | |
|---|---|
| ☐ Sunburn | ☐ Severe Pain |
| ☐ Irritated Skin | ☐ Cold / Flue |
| ☐ Headache | ☐ Inflammation |
| ☐ Cortisone injection in last month | ☐ Poison Ivy |
| ☐ Open cuts, bruises, burns | ☐ Recent cosmetic procedure (Botox) |

9. Please list any other discomforts or concerns: _____

_____

Please read the following and sign / date below:

- ☐ I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- ☐ I understand that his is a non-sexual massage.
- ☐ Conservative draping will be used at all times during the session.
- ☐ As the client, I have the right to terminate the session if I am uncomfortable in any way. Additionally, the therapist has the right to terminate the session if uncomfortable in any way.
- ☐ Massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat physical or mental illness.
- ☐ I will communicate with my therapist to determine the appropriate pressure and will notify the therapist immediately if I experience any pain or discomfort.
- ☐ I understand the services provided are for the basic purpose of alleviating pain, increasing mobility and reducing muscle tension and stress.
- ☐ I have read and understand the scheduling policy form and agree to the policies.

By signing this I confirm that all the information I provided is true and accurate. I am aware that failure to alert the therapist to any medical conditions could result in adverse effects. I hereby voluntarily assume all risks, loss, damage or injury. I also have read and understand and agree to the above policies.

_____ _____

Client Signature Date Client Name (Print)

I agree to the above notices. and as a therapist, will abide to clients wishes and restrictions as long as they are within my scope of practice and professional code of ethics.

_____ _____

Therapist Signature Date Therapist Name (Print)