California Holistic Institute
Personal Health Information

Personal Data

Name:_____ Date:_____
Address:_____ Phone:_____
City/State/Zip:_____ Email: _____
Date of Birth:_____ Occupation:_____
Emergency Contact:_____ Phone:_____

Massage History/ Treatment Information

Have you ever received a professional massage? Yes_____No_____ If yes, frequency_____Date of last massage_____

What results do you want from your massage session?_____

Prioritize the areas of your body that you would prefer to be massaged:_____

Please check the areas of your body that you give permission to receive massage:

Back _____Legs _____Buttocks _____ Arms _____ Abdomen _____ Upper Chest _____Neck _____ Head_____
Face _____Feet _____Others:_____

Are you currently seeing a medical practitioner? Yes_____No_____ If yes, please explain:_____

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

Previous History (include year and treatment received)

Injuries / Surgeries:_____

_____

_____

Informed Consent

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from the muscular tension, spasm, pain or for increasing circulation or energy flow. I agree to communicate with my student practitioner any time I feel that my well-being is being compromised. I understand that due to the nature of this exchange the Institute, the instructors, and the student assume no liability in relation to my massage treatment, nor do they guarantee a specific result or outcome. I understand that a massage is non-sexual and if any advances are made towards the student practitioner, the session will be terminated immediately.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental conditions, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the student practitioner, or the school of any changes in my health status.

Signature: _____ Date: _____