Journey Therapeutic Massage

New Client Health History Form

Client Contact Information:

Client Name: _____Date: _____

Date of Birth: _____Gender: _____

Address: _____

Phone: _____Email: _____

Would you like to be added to our email mailing list? Yes No

Referred by: _____

Emergency Contact: _____Phone: _____

Physician: _____Phone: _____

Massage Information

Have you ever received professional massage before? Yes No If yes, how recently? _____

What kind of pressure do you prefer? Light Medium Firm Not Sure

What are your goals/expected outcomes for receiving massage/bodywork?

Do you have any **implants** that could affect today's massage session, such as dental, hearing, breast, birth control (surgically implanted under the skin of the upper arm, such as Nexplanon) or electronic pain management stimulator? _____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Y N
If yes, explain:

_____

Have you applied any topical creams to your skin today that contain medicine or hormones? Y N

_____

List the medications you currently take:

Are you wearing contacts?	Yes	No
Are you wearing dentures?	Yes	No
Are you wearing a hairpiece?	Yes	No
Are you pregnant?	Yes	No
Are you left or right handed?	Left	Right

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

Circle any of the following health conditions that you currently have (if you are unsure, please ask):

blood clots infections congestive heart failure contagious diseases pitted edema

Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received. CIRCLE the ones that apply.

Current Past Muscle or joint pain_____
Current Past Muscle or joint stiffness_____
Current Past Numbness or tingling_____
Current Past Swelling_____
Current Past Bruise easily_____
Current Past Sensitive of touch/pressure_____
Current Past High/low blood pressure_____
Current Past Stroke/heart attack_____
Current Past Varicose veins_____
Current Past Shortness of breath, asthma_____
Current Past Cancer_____
Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____
Current Past Epilepsy, seizures_____
Current Past Headaches, migraines_____
Current Past Dizziness, ringing in the ears_____
Current Past Digestive conditions (e.g. Crohn's, IBS) _____
Current Past Gas, bloating, constipation_____
Current Past Kidney disease, infection_____
Current Past Arthritis (rheumatoid, osteoarthritis) _____
Current Past Osteoporosis, degenerative spine/disk_____
Current Past Scoliosis, other spinal condition_____
Current Past Broken bones_____
Current Past Allergies_____
Current Past Diabetes_____
Current Past Endocrine/thyroid conditions_____
Current Past Depression, anxiety_____
Current Past Memory loss, confusion, easily overwhelmed_____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor, or another qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Cancellation Policy:

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

IMPORTANT: 24-hour advance notice is required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours' advanced notice you will be charged 50% of your session cost.

No-shows: Anyone who either forgets or consciously chooses to forgo their appointment will be considered a "no-show". They will be charged for 100% of their missed appointment

Understanding all of this, I give my consent to receive care.

Client Signature: X_____Date: _____

Parent of Guardian Signature (in case of minor): _____