Health History Form

Name_________________________________ Date of Birth_________________ Gender___________

Address_____________________________________ CIty_____________State_____ Zip_________

Phone_______________________________ Occupation________________________

Email____(used for appointment confirmation and quarterly emails)

Referred By____

Emergency Contact_____________________Phone_________________Relationship______________

Have you ever had a professional massage before?_______ If so, when was your last treatment?_________

Are you pregnant?_______If so, how many weeks? ________(Women in first trimester are not able to receive massage therapy.)

Are you on any medications? Please list and explain____

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What are your goals for today's session?____

Do you have a pressure preference? ☐ Light ☐ Medium ☐ Firm Pressure

What type of massage are you seeking today? ☐ Therapeutic ☐ Deep Tissue ☐ Pregnancy

Do you have nut allergies or sensitivity to any scents or lotions?________________________________

What are your common areas of tension?____

Please indicate any condition that you have had or currently have:

☐ Headache / Migraines	☐ TMJ Problems	☐ Major Accidents
☐ Allergies / Sensitivity	☐ Skin Condition	☐ Varicose Veins
☐ Arthritis/Tendonitis	☐ Heart / Circulation Problems	☐ Blood Clots
☐ Bruise Easily	☐ Joint Replacement / Surgery	☐ Epilepsy / Seizures
☐ Cancer / Tumors	☐ High / Low Blood Pressure	☐ Diabetes
☐ Fibromyalgia	☐ Numbness	☐ Sprains / Strains
☐ Recent Injury	☐ Neck / Back Injuries	☐ Surgery

Please explain any condition you have marked above____

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COVID-19 Health Information & Informed Consent Client

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐

2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes ☐ No ☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

To proceed with receiving care, I confirm and understand the following
(Initial in all places provided)

____________I understand that for this upcoming appointment and future appointments, if any of the above questions become true I will reschedule my appointment for a minimum of two weeks, or until I have been cleared by my physician.

____________I agree to wear a mask when asked and to respect the protocols in place during my treatment in order to reduce the spread of COVID-19.

____________ I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices regarding massage therapy in light of COVID-19. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic.

____________ I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19.

_____________ I Knowingly And Willingly Consent To The Treatment With The Full Understanding And Disclosure Of The Risks Associated With Receiving Care During The Covid-19 Pandemic. I Confirm All Of My Questions Were Answered To My Satisfaction. I Have Read, Or Have Had Read To Me, The Above Covid-19 Risk Informed Consent To Treat. I Appreciate That It Is Not Possible To Consider Every Possible Complication To Care. I Have Also Had An Opportunity To Ask Questions About Its Content, And By Signing Below, I Agree With The Current Or Future Recommendation To Receive Care As Is Deemed Appropriate For My Circumstance.

Signature____ **Date**_________________

Client Consent for Treatment

Please read carefully and sign below.

By signing this consent, I agree that I have stated all conditions that I am aware of and the information is true and accurate to the best of my knowledge. I will inform my health care provider and my massage therapist if anything changes in my status. I understand that the massage/bodywork I receive is for the purpose of stress reduction and relief from muscular tension, spasm, or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist that the pressure and/or methods can be adjusted to my comfort level.

I understand that a massage therapist cannot diagnose illness, disease, or any physical or mental disorders. I understand that massage therapy is not a substitute for a medical examination.

I agree to respect the space and nature of massage therapy. Sexual advances and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated, resulting in immediate termination of the treatment and I will be liable for payment of the scheduled treatment. Authorities will be contacted.

I agree to abide by a 24 hour cancellation notice for any scheduled massage. I understand I may be charged a $25 fee for missed appointments or any cancellations with less than a 24 hour notice. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

Print Name____

Signature____

Date______________________________