



Client Health History

Please print all information.

Name:

Address:

City: | State: | Zip:

Home Phone: () - | Work: () -

Cell Phone: () -

Occupation:

Age: Date Born : / / **Email:** @

How did you hear about Hands for Health Massage? *(Please be specific, friend, doctor, etc.)*

What brings you in for a massage today?

Health History: Please check the conditions that you have or experience frequently:

<input type="checkbox"/>	headaches	<input type="checkbox"/>	vision problems	<input type="checkbox"/>	contact lenses	<input type="checkbox"/>	muscles/joints
<input type="checkbox"/>	skin problems	<input type="checkbox"/>	neck pain	<input type="checkbox"/>	poor circulation	<input type="checkbox"/>	pain
<input type="checkbox"/>	carpal tunnel	<input type="checkbox"/>	scoliosis	<input type="checkbox"/>	pregnant	<input type="checkbox"/>	stiffness
<input type="checkbox"/>	allergies	<input type="checkbox"/>	frequent colds	<input type="checkbox"/>	chronic cough	<input type="checkbox"/>	swelling
<input type="checkbox"/>	shoulder pain	<input type="checkbox"/>	fibromyalgia	<input type="checkbox"/>	chronic fatigue	<input type="checkbox"/>	limited movement
<input type="checkbox"/>	stroke	<input type="checkbox"/>	liver/gall bladder	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	thyroid
<input type="checkbox"/>	low blood pressure	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	varicose veins	<input type="checkbox"/>	osteoarthritis
<input type="checkbox"/>	arthritis	<input type="checkbox"/>	cancer	<input type="checkbox"/>	rheumatoid arthritis	<input type="checkbox"/>	depression
<input type="checkbox"/>	kidney/bladder	<input type="checkbox"/>	earaches	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	Parkinson's
<input type="checkbox"/>	sinus	<input type="checkbox"/>	constipation	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	seizures
<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	back pain	<input type="checkbox"/>	difficulty with digestion	<input type="checkbox"/>	

Over Please ☺☺

Do you Smoke? Yes No

Do you exercise regularly? Yes No

Do you eat a balanced diet? Yes No

What is your stress level? Extreme High Medium Low/None

How are your sleep habits? Good Fair Poor

Describe your overall health, any surgeries/injuries and the dates they occurred. (Last 12 Months)

List all current medication and condition/s being treated.

Please advise of any pins, screws, wires, artificial joints or limbs.

How do you feel Today?

Currently under Treatment at/with:

Chiropractic Psychotherapy Osteopathy Physical Therapy Homeopathy

Have you had massage before? Yes No

PLEASE READ AND SIGN:

I understand that the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm, and for improving circulation. I understand that a massage therapist neither diagnoses illness, disease or any other medical, physical, or mental disorder nor performs any spinal manipulations. I understand that it is the right of the therapist to refuse or discontinue treatment according to medical conditions, noncompliance with ethical codes, or sexual misconduct.

Signature: _____

Today's Date: _____