

# Health History Form

## Section 1: Personal Information

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Name: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M F

Mailing Address: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

\_\_\_\_\_  
City State Zip Occupation: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone: (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_ (Cell) \_\_\_\_\_

Please List Your Preferred Contact Number: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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Hobbies: \_\_\_\_\_

Have you ever had a massage before? \_\_\_\_\_

When was your last massage? \_\_\_\_\_

How did you hear about our service? \_\_\_\_\_

Referred By: \_\_\_\_\_

What is your primary reason for making this appointment? \_\_\_\_\_

Is there any part of the body that you **do not** like worked on? (e.g. face, feet, hands, glutes)

Hand Dominance: Right \_\_\_\_ Left \_\_\_\_

Introvert \_\_\_\_ Extrovert \_\_\_\_

Level of Personal Stress (1-10) \_\_\_\_\_

## Section 2: Medical Information

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Are you currently under a physician's care? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Chiropractor: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Health Practitioners: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you presently taking any medications? \_\_\_\_\_ If yes, please list the medications and what they are prescribed for.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Allergies: Please list any known allergies since certain products contain ingredients that can cause allergic reactions, e.g. latex, iodine, seaweed, wheat, etc.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Previous Surgeries: Please list any surgeries you have had, and the date of the surgery.

1. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_
2. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_
3. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

**Please place a “C” by any Current conditions and an “F” by any Former conditions.**

Please answer all questions thoroughly and honestly. We are not here to judge you; all information you provide is kept completely confidential, but to avoid any contraindications that could negatively affect your treatment, we must be fully informed.

**Musculo-Skeletal**

- Headache
- Neck/Shoulder/Arm Pain
- Back Pain
- Low Back/Hip/Leg Pain
- Arthritis (Osteo or Rheumatoid)
- Sprains/Strains
- Stiff Neck
- Spinal Curvature (Scoliosis, Lordiosis, Kyphosis)
- Whiplash
- Jaw Pain/TMJ
- Bursitis
- Hernia
- Bad/Faulty Posture
- Spasms/Cramps
- Broken Bones/ Fractures
- Fibromyalgia
- Decreased Range of Motion

**Gastro-Intestinal**

- Chronic Belching or Flatulence
- Colitis
- Constipation
- Diverticulitis/Diverticulosis
- Hemorrhoids
- Irritable Bowel Syndrome

**Circulatory**

- High/Low Blood Pressure
- Heart Condition
- Varicose Veins
- Blood Clots
- Breathing Difficulty
- Rapid Beating Heart
- Slow Beating Heart
- Poor Circulation

**Integumentary (Skin)**

- Skin Eruptions
- Allergies \_\_\_\_\_
- Rashes - Location \_\_\_\_\_
- Fungal Infections - Location \_\_\_\_\_
- Sensitive Skin
- Warts - Location \_\_\_\_\_

**Respiratory**

- Chronic Cough
- Asthma
- Chest Pain

**Male**

- Frequent Urination
- Prostatitis
- Other \_\_\_\_\_

**Female**

- PMS
- Pregnancy - Trimester
- Hot Flashes
- Menopause
- Frequent Urination
- Other \_\_\_\_\_

**Nervous System**

- ADHD/ADD
- Epilepsy
- Bi-Polar
- Depression
- Fatigue
- Herpes/Shingles– Type \_\_\_\_\_
- Chronic Pain
- Numbness/Tingling - Location \_\_\_\_\_
- Sleeping Disorders (Insomnia/Narcolepsy)

**Other**

- Inflammation - Location \_\_\_\_\_
- Drug/Alcohol Addiction
- Diabetes
- Eating Disorder
- Cancer/Tumor - Type \_\_\_\_\_
- Tuberculosis (Active - Inactive - Don't Know)
- HIV
- AIDS
- Hepatitis - Type \_\_\_\_\_
- Serious Accidents (Please list all current and former - e.g. car accidents, falls, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
- Other Conditions Not Listed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 3: Activity Information**

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Do you smoke? \_\_\_\_\_

Do you drink caffeinated beverages? \_\_\_\_\_ Number per Day: \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_

How much water do you drink daily? Number of glasses per day: \_\_\_\_\_

Do you participate in any of the following?

<b>Activity</b>	<b>Frequency (times per week)</b>
Walking	_____
Jogging	_____
Swimming	_____
Aerobics	_____
Weight Training	_____
Bicycling	_____
Racquet Sports	_____
Other	_____

**Late/Cancellation Policy**

Because everyone’s time is valuable, we ask that you provide a 24-hour notice for all canceled appointments. Appointments not canceled within 24 hours prior to service time are subject to a cancellation fee.

We will do everything we can to accommodate late arrivals, but please be aware that if you arrive late to your appointment you may be required to reschedule for another time or your services may be abbreviated to fit your scheduled appointment time.

**Pricing/Gift Certificate Policy**

We strive to provide excellent services at low rates, however all prices are subject to change. Full payment is always expected when services are rendered, and a \$35.00 charge will be applied to your account for each returned check. Gratuity is not included in your spa service price, but is *highly* appreciated.

Gift Certificates are non-refundable, but may be used for services of your choice. Lost or stolen gift certificates cannot be replaced, and once a gift certificate is expired, it is no longer valid (no exceptions).

**Coupon Policy**

Multiple coupons cannot be accepted for the same service, and if a coupon is printed with a specific name, that coupon can only be redeemed by the named individual.

**Privacy Policy**

We respect your privacy. You will be full draped or covered during all treatments. If you wish, you may bring a bathing suit for body services, and disposable undergarments will be provide otherwise. If at any time you feel uncomfortable, *please* express this to your therapist.

**Authorization**

I have read the information above and honestly answered all questions on this form. It is my choice, as a client, to receive this treatment for the therapeutic nature of my mind and body. I give the technician/therapist my permission for treatment, and understand that **any misconduct, verbal or nonverbal**, will lead to immediate termination of my session. I further understand that I will be responsible for full payment of my session if terminated for any misconduct.

I understand that the technician/therapist does not give diagnoses for any illness, disease, or any other physical or mental disorder. I further understand that the technician/therapist does not perform spinal manipulations, or prescribe any pharmaceutical or medical treatments. I acknowledge that I should seek medical advice from a doctor for any conditions I may have questions about.

I agree to **communicate** with my therapist. If I feel that my well-being is being compromised, or I, in any way, become uncomfortable during a session I am responsible for letting my therapist know what I am experiencing. I have stated all medical conditions on the front and back of this form that I am aware of, and will advise my therapist of any changes in my health status prior to subsequent sessions.

Client Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_