



## Client Health History Form

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male Female Referred by: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Mobile ( ) \_\_\_\_\_ - \_\_\_\_\_

I would like to receive promotions and updates for Resolution via email:  Yes  No

Occupation \_\_\_\_\_ Health Insurance Carrier \_\_\_\_\_

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### Emergency Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Mobile ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_

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Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage session? \_\_\_\_\_ Yes \_\_\_\_\_ No

What are your goals for this session?

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Which area would you like to receive the most focus?

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{turn over}

Please mark any of the following questions to indicate a “yes” answer.

- |   |  |
|---|--|
| <input type="checkbox"/> Do you frequently suffer from stress?          | <input type="checkbox"/> Do you have any allergies? (Nuts, oils?)              |
| <input type="checkbox"/> Do you have diabetes? Type _____               | <input type="checkbox"/> Do you bruise easily?                                 |
| <input type="checkbox"/> Do you experience frequent headaches?          | <input type="checkbox"/> Any broken bones in the last two years?               |
| <input type="checkbox"/> Are you pregnant? Due Date _____               | <input type="checkbox"/> Any injuries in the last two years?                   |
| <input type="checkbox"/> Do you suffer from arthritis?                  | <input type="checkbox"/> Do you have cardiac or circulatory problems?          |
| <input type="checkbox"/> Are you wearing contact lenses?                | <input type="checkbox"/> Do you suffer from back pain?                         |
| <input type="checkbox"/> Do you have high blood pressure?               | <input type="checkbox"/> Do you have numbness or stabbing pains?               |
| <input type="checkbox"/> Are you taking high blood pressure medication? | <input type="checkbox"/> Are you sensitive to touch or pressure in any area?   |
| <input type="checkbox"/> Do you suffer from epilepsy or seizures?       | <input type="checkbox"/> Have you ever had surgery?                            |
| <input type="checkbox"/> Do you suffer from joint swelling?             | <input type="checkbox"/> Are you taking any medications? (Including Ibuprofen) |
| <input type="checkbox"/> Do you have varicose veins?                    | <input type="checkbox"/> Other medical conditions                              |
| <input type="checkbox"/> Do you have any contagious diseases?           |  |
| <input type="checkbox"/> Do you have osteoporosis?                      |  |

Comments:

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# AGREEMENT

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other 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.

LATE CANCELLATION OR NO SHOW POLICY: I (the undersigned) agree to pay Resolution Therapeutic Massage 50% of scheduled services if I fail to cancel my appointment 24 hours in advance, or if I miss my scheduled appointment entirely.

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

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## Consent to Treatment of Minor

By my signature below, I hereby authorize \_\_\_\_\_ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_