HEALTH STUDIO CLIENT INFORMATION AND HEALTH HISTORY

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions about your session or treatment plan, please let me know.

NAME:_____**DATE OF BIRTH:**_____

ADDRESS: _____

CITY:_____**STATE:**_____**ZIP CODE:**_____

HOME PHONE:_____**WORK PHONE:**_____**CELL PHONE:**_____

EMPLOYER:_____**OCCUPATION:**_____**MARITAL STATUS:**_____

EMERGENCY CONTACT:_____**RELATIONSHIP**_____**PHONE:**_____

EMAIL ADDRESS:_____**REFERRED BY:**_____

Have you ever had a Professional Massage Before? _____**If Yes, how frequently**_____

What do you hope to accomplish from todays massage?_____

Are you aware of any tension holding spots in your body?_____**If Yes, location(s)**_____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago:_____

More than 5 years ago:_____

What type of care did you receive for your accidents or injuries?_____

Do you feel you have recovered from these events?_____**Please explain:**_____

Do you have any chronic, ongoing pain that you deal with on a regular basis?_____**Please explain:**_____

_____

Describe what activities cause this pain and/or make it worse:_____

Are you receiving any other type of medical treatment?_____**Please explain:**_____

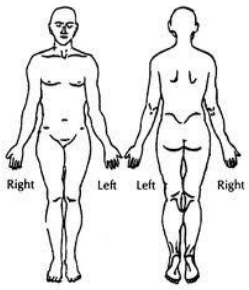
Please list any medications (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what each medication is used to treat):_____

Are you currently under the care of a physician?_____**Whom?**_____

Please list reason(s):_____

Are there any health concerns you wish to discuss today_____**If yes, please describe:**_____

Please indicate with an (X) any areas that you are feeling pain or discomfort:



Are you currently experiencing any of the following conditions:

Flu or cold_____ Inflammation _____ Fever_____ Infection_____ Rash_____ Cuts_____ Contagious Disease_____

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years:

MUSCULOSKELETAL
___Fibromyalgia
___Spasms/Cramps
___Sprains/Strains
___Osteoporosis
___Postural Deviations
___Gout
___Osteoarthritis/Rheumatoid Arthritis
___TMJ
___Cysts
___Bursitis
___Plantar Fasciitis
___Tendonitis
___Torticollis
___Whiplash Syndrome
___Carpal Tunnel Syndrome
___Headache
___Leg Pain
___Arm Pain/Shoulder Pain
___Mid Back Pain
___Low Back Pain
___Hip Pain ___Right___Left
___Other_____

RESPIRATORY
___Pneumonia
___Sinusitis
___Asthma
___Trouble Breathing
___Dizziness
___Other_____

CIRCULATORY
___Anemia
___Hemophilia
___Hypertension
___Low Blood Pressure
___Raynaud's Disease
___Varicose Veins
___Heart Condition
___Blood Clots/Phlebitis
___Diabetes
___Ohter_____

DIGESTIVE
___Ulcers
___Irritable Bowel Syndrome
___Colitis
___Gallstones
___Hepatitis
___Crohn's Disease
___Diarrhea
___Gas/Bloating
___Indigestion
___Other_____

SKIN
___Fungal Infections
___Acne
___Impetigo
___Dermatitis/Eczema
___Psoriasis
___Open Wound or Sore
___Rashes
___Warts/Moles
___Athletes Foot
___Other_____

NERVOUS SYSTEM
___ALS
___Multiple Sclerosis
___Parkinson's Disease
___Bell's Palsy
___Neuritis
___Spinal Cord Disease
___Stroke
___Trigeminal Neuralgia
___Seizure Disorders
___Numbness/Tingling/Twitching
___Other_____

OTHER
___Insomnia
___Anxiety/Panic Attacks
___PMS
___Grief Process
___Cancer
___Substance Abuse
___Pregnancy
___Chronic Fatigue
___HIV/AIDS
___Lupus
___Kidney Disease
___Kidney Stone(s)
___Bladder Infection
___Postoperative Situation
___Edema
___Other_____

The above information is accurate and true to the best of my knowledge. I understand that Massage Therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical examination, diagnosis and treatment. I take responsibility for advising my therapists to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hour notice (medical emergencies excluded) may be charged in full for the price of the missed session. I understand that my Personal Health Information will be handled by the policies described in the Health Studio HIPAA guidelines. By signing I agree to these policies.

SIGNATURE_____DATE:_____