MATHEWS MOBILE MASSAGE

Client Health History

Your confidential health history is being requested for your health and safety. Massage affects a variety of body systems. Your response on the following questions will help us create a session plan for you and your needs. In some cases, certain health conditions may need a primary care physician's approval before proceeding with massage protocol. Your cooperation and understanding is appreciated.

Name: _____ Date: _____

Address: _____ City, State, Zip: _____

Phone (preferred): _____ Phone (alternate): _____

Occupation: _____ Email: _____

Date of Birth: _____ Height/Weight: _____

Are you currently under the care of a physician? __NO __YES If yes, please indicate condition:

_____

Physician Information – Name and Phone: _____

Are you currently taking any medications? __NO __ YES If yes, please indicate medication(s):

_____

What physical activities do you do on a daily or weekly basis? _____

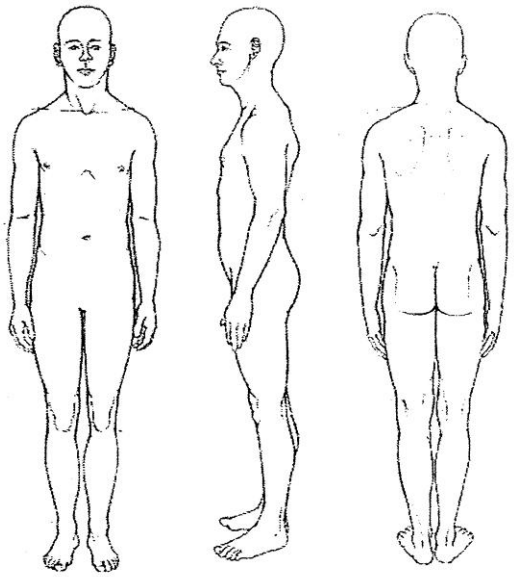
_____

Do you wear contact lenses? __NO __YES Do you wear dentures or other appliances? __NO __YES

On a scale of 0 (no tension) to 10 (high levels of stress), please indicate the amount of tension in your life:

0 1 2 3 4 5 6 7 8 9 10

On the figures to the right, please indicate the areas where you carry the most tension, are experiencing discomfort, or hold stress.



What is your reason for today's visit?

_____

Ever had any accidents? __NO __YES

If yes, please indicate details:

_____

Do you consider yourself fully recovered?

___ NO ___YES

Have you been hospitalized in the past two years?

__NO __YES Indicate condition:

_____

Are there any areas that you DO NOT want addressed during your session? _____

General Medical Information: For your safety, your therapist must be aware of any history of the following medical conditions. Therapeutic massage may affect these conditions and your health. Please indicate if you have ever experienced or are experiencing any of the following:

Medical Conditions	YES	NO	Location and Description
1. Any areas of infection, cuts, or open skin?	☐	☐	
2. Any areas of swelling, edema, or tendency to swell?	☐	☐	
3. Any areas of numbness or altered sensation?	☐	☐	
4. Any areas of pain or tenderness?	☐	☐	
5. Arthritis	☐	☐	
6. Cancer or tumors	☐	☐	
7. Cardiovascular Disease	☐	☐	Please circle any that apply: Anemia, Angina, Ateriosclerosis, Congestive Heart Failure, Phlebitis/Thrombosis Heart Attack, Heart Murmur, Hemophilia, Hypertension, Varicose Veins, Other: _____
8. Diabetes	☐	☐	
9. Injuries	☐	☐	
10. Kidney, Liver, or Urinary Problems	☐	☐	
11. Respiratory Conditions	☐	☐	
12. Skin Conditions	☐	☐	Please circle any that apply: Acne, Abrasions/Cuts, Birthmarks/moles, Bruises, Dermatitis, Eczema, Herpes, Hives, Poison Ivy/Oak/Sumac, Psoriasis, Skin Tags, Warts, Sunburns, Other: _____
13. Surgery	☐	☐	
14. Gastrointestinal Problems	☐	☐	
15. Pregnancy	☐	☐	Please circle any that apply: Currently pregnant, postpartum (within 6 weeks), spontaneous or elective abortion in recent 6 weeks, currently breastfeeding.

I understand and agree to the following:

1. Massage therapy is for the purpose of stress reduction, relief from muscular tension, general relaxation and improvement of circulation;
2. The massage therapist does not diagnose illness, disease, or physical or mental disorders and does not prescribe medical treatments or pharmaceuticals, nor do they perform spinal manipulations;
3. Massage therapy is not a substitute for medical treatment and it is recommended that I see a physician for any physical ailment I might have;
4. Sessions will vary according to the needs of the client for that particular session, and therapist has the right to decline a client's requests for work if it falls outside the therapist's scope of training or education;
5. All the information I (the client) have provided is correct and current to the best of my knowledge, and I will update my health history form in the future with any changes in my physical health if need be;
6. Any information provided by the therapist is for educational purposes only and is not prescriptive or diagnostic in nature;
7. I am encouraged to state my preferences and requests to the therapist. I understand that it is important for me to communicate with my therapist during the session as well in order for the therapist to adjust to any aspect of the work;
8. All treatments start and end within the specified time;
9. I will turn my cell phone off while in session;
10. Any inappropriate or sexual behavior will not be tolerated and will abruptly end the session. I will still be held financially responsible for the full session cost and will not be rescheduled with this practice or therapist again.
11. I will not hold the therapist responsible for any personal injury while in or on the premises before, during, or after a session, nor will I hold him/her responsible for any loss of property.
12. I have been given a copy of the policies, and I have read an understood them thoroughly.

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date:_____